Original

Erlanger Behavioral Health, LLC.

CN1603-012

CERTIFICATE OF NEED APPLICATION

Erlanger Behavioral Health, LLC

Application To Initiate Psychiatric Services At The
Intersection Of North Holtzclaw Avenue And Citico Avenue,
In Chattanooga, Tennessee, With Establishment
Of An Eighty-Eight (88) Bed Inpatient Hospital
By The Addition Of Seventy-Six (76) Psychiatric Beds
And The Transfer Of Twelve (12) Geriatric-Psychiatric Beds
From *Erlanger North Hospital*

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

Section A

APPLICANT PROFILE

Section A: APPLICANT PROFILE

Please enter all Section A responses on this form. All questions must be answered. If an item does not apply, please indicate "N/A". ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable item Number on the attachement.***

1. Name of Facility, Agency, or Institution.

Erlanger Behavioral Health, LLC
A Site Located At The Intersection Of
North Holtzclaw Avenue & Citico Avenue
Hamilton County
Chattanooga, TN 37404

2. Contact Person Available For Responses To Questions.

Joseph M. Winick, Sr. Vice President
Planning & Business Development
Erlanger Health System
975 East 3rd Street
Chattanooga, TN 37403
(423) 778-8088
(423) 778-5776 -- FAX
Joseph.Winick@erlanger.org -- E-Mail

3. Owner of the Facility, Agency, or Institution.

Erlanger Behavioral Health, LLC
975 East 3rd Street
Hamilton County
Chattanooga, TN 37403

4. Type of Ownership or Control.

A.	Sole Proprietorship	
B.	Partnership	
C.	Limited Partnership	
D.	Corporation (For Profit)	
E.	Corporation (Not-for-Profit)	
F.	Governmental (State of TN or Political Subdivision)	
G.	Joint Venture	
H.	Limited Liability Company	X

I. Other (Specify) _____

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

-- A copy of the *Articles Of Organization* issued by the Tennessee *Secretary of State* is attached at the end of this CON application.

5. Name of Management / Operating Entity (if applicable).

*** Not Applicable. ***

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. Legal Interest in the Site of the Institution

(*Check One*)

A.	Ownership	_____
B.	Option to Purchase	X
C.	Lease of _____ Years	_____
D.	Option to Lease	_____
E.	Other (Specify)	_____

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

7. Type of Institution

(*Check as appropriate - more than one response may apply*)

A.	Hospital (Specify) _____	_____
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty	_____
C.	ASTC, Single Specialty	_____
D.	Home Health Agency	_____
E.	Hospice	_____
F.	Mental Health Hospital	X
G.	Mental Health Residential Treatment	

	Facility	
H.	Mental Health Institutional Habilitation Facility (ICF/MR)	
I.	Nursing Home	
J.	Outpatient Diagnostic Center	
K.	Recuperation Center	
L.	Rehabilitation Facility	
M.	Residential Hospice	
N.	Non-Residential Methadone Facility	
O.	Birthing Center	
P.	Other Outpatient Facility (Specify) _____	
Q.	Other (Specify) _____	

8. Purpose of Review

(Circle Letter(s) as appropriate - more than one response may apply)

A.	New Institution	X
B.	Replacement/Existing Facility	
C.	Modification/Existing Facility	
D.	Initiation of Health Care Service As Defined In TCA § 68-11-1607(4) (Specify) Psychiatric Services	X
E.	Discontinuance of OB Services	
F.	Acquisition of Equipment	
G.	Change in Beds	X
	[*Please note the type of change by underlining the appropriate response:* Increase, Decrease, Designation, Distribution, Conversion, Relocation]	
H.	Change of Location	
I.	Other (Specify) _____	

9. Bed Complement Data

Please indicate current and proposed distribution and certification of facility beds.

		Licensed Beds	*(*) CON Beds*	*Staffed Beds*	*Beds Proposed*	*TOTAL Beds at Completion*
A.	Medical					
B.	Surgical					
C.	Long-Term Care Hospital					
D.	Obstetrical					
E.	ICU / CCU					
F.	Neonatal					
G.	Pediatric					
H.	Adult Psychiatric				24	24
I.	Geriatric Psychiatric				24	24
J.	Child / Adolescent Psychiatric				18	18
K.	Rehabilitation					
L.	Nursing Facility (Non – Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid / Medicare)					
P.	ICF / MR					
Q.	Adult Chemical Dependency				22	22
R.	Child and Adolescent Chemical Dependency					
S.	Swing Beds					
T.	Mental Health Residential Treatment					
U.	Residential Hospice					
	TOTAL				88	88

(*) CON Beds approved but not yet in service.

Notes
(1) *Erlanger Behavioral Health* seeks approval for the addition of 76 psychiatric beds with this CON.
(2) *Erlanger North Hospital* currently operates twelve (12) Geriatric-Psychiatric beds and will transfer these beds to *Erlanger Behavioral Health*.

10. **Medicare Provider Number** Application will be made prior to opening of the facility.

Certification Type _____

11. **Medicaid Provider Number** Application will be made prior to opening of the facility.

Certification Type _____

12. If this is a new facility, will certification be sought for Medicare and / or Medicaid ?

Yes __X__ No _____

***13. Identify all TennCare Managed Care Organizations / Behavioral Health Organizations (MCO's/BHO's) operating in the proposed service area.* Will this project involve the treatment of TennCare participants ?** *Yes* **If the response to this item is yes, please identify all MCO's/BHO's with which the applicant has contracted *or plans to contract*.**

Discuss any out-of-network relationships in place with MCO's/BHO's in the area.

Response

It is anticipated that *Erlanger Behavioral Health* will have patient service agreements with substantially the same Managed Care Organizations ("MCO's") as *Erlanger Health System*, as well as other Behavioral Health Organizations ("BHO's"). These agreements will be developed separately from the MCO contracts which are currently in place with *Erlanger Health System*.

Erlanger Health System is well positioned to develop agreements with MCO's and BHO's in the service area. With the initiation of the *Health Care Exchanges* under the *Affordable Care Act* on January 1, 2014; *Blue Network E* enrolled over 10,000 uninsured people and *Erlanger* is the only provider in this network. Further, an additional 7,000 people were enrolled in *Blue Network S* and *Erlanger* is one of only two providers in this network. *Erlanger* is the low cost and safety net provider in the regional service area and participates in narrow networks to facilitate needed care for those who would otherwise not be able to receive it.

Erlanger Health system currently has contracts with the following MCO's.

A. TennCare Managed Care Organizations

-- BlueCare
-- TennCare *Select*
-- AmeriGroup Community Care
-- United Healthcare Community Plan

B. Georgia Medicaid Managed Care Organizations

-- AmeriGroup Community Care
-- Peach State Health Plan
-- WellCare Of Georgia

C. Commercial Managed Care Organizations

-- Blue Cross / Blue Shield of Tennessee
  - Blue Network P
  - Blue Network S
  - Blue Network E
  - Blue CoverTN
  - Cover Kids
  - AccessTN
  - Blue Advantage
-- Blue Cross of Georgia (HMO & Indemnity)
-- Baptist Health Plan
-- CIGNA Healthcare of Tennessee, Inc.
  (includes LocalPlus)
-- CIGNA Lifesource (Transplant Network)
-- UNITED Healthcare of Tennessee, Inc.
  (Commercial & Medicare Advantage)
-- Aetna Health
-- Health Value Management D/B/A Choice Care Network (Commercial & Medicare Advantage)
-- HUMANA
  (Choicecare Network, HMO, PPO, POS & Medicare Advantage)
-- HUMANA Military
-- Cigna-HealthSpring
  (Commercial & Medicare Advantage)
-- WellCare Medicare
-- Olympus Managed Health Care, Inc.
-- TriWest (VAPC3)

D. Alliances

-- Health One Alliance

E. Networks

-- Multi-Plan (includes Beech Street & PHCS)
-- MCS Patient Centered Healthcare
-- National Provider Network
-- NovaNet (group health)
-- USA Managed Care Corp.
-- MedCost
-- Alliant Health Plan
-- Crescent Preferred Provider Organization
-- Evolutions Healthcare System
-- Prime Health Resources
-- Three Rivers Provider Network
-- Galaxy Health Network
-- First Health Network
-- Integrated Health Plan
-- Logicomp Business Solutions, Inc.
-- HealthSCOPE Benefits, Inc.
-- HealthCHOICE (Oklahoma State & Education Employees Group Insurance Board)

F. Other

-- Alexian Brothers Community Services

Section B

PROJECT DESCRIPTION

Section B: PROJECT DESCRIPTION

Please answer all questions on 8 ½" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

Response

Erlanger Behavioral Health, will be the region's safety net provider for adults and children. *Erlanger Behavioral Health* seeks approval to construct and initiate inpatient psychiatric services in a new, state of the art, psychiatric hospital. This project represents *Erlanger Health Systems'* effort to enhance its system of care to meet the needs of the vulnerable population's in the four (4) state geography of the defined service area.

Disparity in mental health status and mental health care are critical in determining the greatest need. Specifically, "Blacks, Latino's and Asian Americans are over represented in populations that are particularly at risk for mental health disorders. Additionally, minority individuals may experience symptoms that are undiagnosed, under-diagnosed, or mis-diagnosed for cultural, linguistic, or historical reasons. The lack of attention to the mental and behavioral health needs of racial and ethnic minorities and the inadequate provision of culturally and linguistically appropriate mental health care in racial and ethnic minority communities demonstrates a clear need … to close the gap in care."[1] It should also be noted that in Tennessee, in 2015 the number of poor mental health days

1 *Health Care Reform – Disparities In Mental Health Status & Mental Health Care*, American Psychological Association website … http://www.apa.org/about/gr/issues/health-care/disparities.aspx.

index ranked at 4.8, the worst of every health index measure.

Erlanger Behavioral Health will serve adult (24 beds), geriatric (24 beds), and children / adolescent (18 beds) psychiatric patients, and will also provide adult chemical dependency services (22 beds). Services will include acute inpatient care, partial hospitalization and outpatient care. Further, service will also be provided with a crisis assessment and intake center for patients on an emergency basis, as needed. Behavioral medicine will also be provided to those in need who are affected by various medical conditions.

Proposed Services & Equipment

Erlanger Behavioral Health seeks approval to construct a new state of the art, acute care psychiatric hospital, as well as initiate psychiatric services.

Ownership Structure

Erlanger Behavioral Health will be initially owned by *Erlanger Health System*. It is anticipated that the facility will become a joint ownership arrangement between *Erlanger Health System* and *Acadia Healthcare*.

Acadia Healthcare is the largest provider of behavioral healthcare services. *Acadia* operates a network of 585 behavioral healthcare facilities with approximately 17,100 beds in 39 states, the United Kingdom and Puerto Rico. *Acadia* provides behavioral health and addiction services to its patients in a variety of settings, including inpatient psychiatric hospitals, residential treatment centers, outpatient clinics and therapeutic school-based programs.

Acadia already operates an outpatient methadone treatment clinic in Chattanooga.

Service Area

The service area for this project is defined as Hamilton County, Tennessee, and the counties that surround Hamilton County in Tennessee, Georgia, Alabama and North Carolina. The service area consists of a total of thirty (30) contiguous counties in the four (4) state geography, which is the same service area currently served by *Erlanger Medical Center*. A complete list of the counties which comprise the

service area is attached to this CON application.

Need

The need for this project is clearly demonstrated by a broad based analysis of the service area. In short, the defined service area is in need of an additional 219 inpatient psychiatric beds, based on the current Psychiatric bed need criteria.

Further, in the twelve (12) month period from Oct. 1, 2014 - Sep. 30, 2015, EHS had a total of 34,853 inpatient discharges, and of that there were 11,561 discharges with a mental health condition that needed to be treated. Of the 11,561 inpatient discharges with a mental condition, 6,468 of those patients were admitted as inpatients through the Emergency Dept.

In short, there is a critical need for additional inpatient psychiatric beds from both a community need perspective, as well as an institutional need perspective.

Existing Resources

There are currently a total of five (5) provider organizations delivering inpatient psychiatric and substance abuse / chemical dependency services at a total of seven (7) locations within the defined service area, for a total of 252 licensed inpatient beds.

Project Cost

The project cost (per *HSDA* rules) is $ 25,112,600.

Funding

Funding for this project will be provided by *Acadia Healthcare*.

Financial Feasibility

The *Projected Data Chart* shows a positive financial result in year 2 for the project, year 1 includes the start-up cost and twelve (12) months of expense, but only ten (10) months of revenue. The first two (2) months of year 1 are planned for staff training and facility setup, along with other start-up activities.

Staffing

Staffing for the project in year 2 is estimated to be

100.9 FTE's.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

A. Describe the construction, modification and / or renovation to the facility (exclusive of major medical equipment covered by T.C.A. section 68-11-1601 *et seq.*) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of $ 5 million) and other facility projects (construction cost in excess of $ 2 million) should complete the Square Footage And Cost Per Square Foot Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Part B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above describe the development of the proposal.

Response

This project calls for the construction of a new eighty-eight (88) bed inpatient hospital providing services for both psychiatric and substance abuse / chemical dependency. *Erlanger Health System* is currently in discussions with it's academic partner, the University of Tennessee – College of Medicine, about making the new hospital an academic medical center like Erlanger where a

graduate medical education and training residency program in Psychiatry would be established.

The bed complement for *Erlanger Behavioral Health* will be twenty-four (24) Adult Psychiatric, twenty-four (24) Geriatric Psychiatric, eighteen (18) Child/Adolescent Psychiatric and twenty-two (22) Adult Chemical Dependency beds. The detail calculations are attached to this CON application.

The new facility will be 69,000 SF with construction cost of $ 18,720,000 and total cost of $ 25,112,600.

B. Identify the number of beds increased, decreased, converted, relocated, designated, and/or distributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

Response

Erlanger Behavioral Health seeks to add seventy-six (76) new psychiatric beds to the service area. *Erlanger North Hospital* will transfer it's current complement of twelve (12) licensed geriatric psychiatric beds to *Erlanger Behavioral Health* with approval and implementation of this CON application. This will be a total of eighty-eight (88) beds for the new hospital.

Erlanger Behavioral Health will have a bed mix of twenty-four (24) Adult Psychiatric, twenty-four (24) Geriatric Psychiatric, eighteen (18) Child/Adolescent Psychiatric and twenty-two (22) Adult Chemical Dependency beds.

In the twelve (12) month period from Oct. 1, 2014 - Sep. 30, 2015, EHS had a total of 34,853 inpatient discharges, and of that there were 11,561 discharges with a mental health condition that needed to be treated. Further, of the 11,561 discharges with a mental condition, 6,468 of those patients were admitted through the Emergency Department. As the 7th largest public health system in the nation, and the healthcare safety net for the region, *Erlanger Health System* is already the defacto provider of behavioral health services for those in need, serving those

who are unable to access care elsewhere. Patients with cancer, cardiac or other complex medical conditions will benefit greatly from the provision of behavioral medicine provided on an outpatient basis. Having a "system of care" available to meet the needs of area residents is paramount to foster access as well as coordinate population health.

Further, disparity in mental health status and mental health care are critical in determining the greatest need. Specifically, "Blacks, Latino's and Asian Americans are over represented in populations that are particularly at risk for mental health disorders. Additionally, minority individuals may experience symptoms that are undiagnosed, under-diagnosed, or mis-diagnosed for cultural, linguistic, or historical reasons. The lack of attention to the mental and behavioral health needs of racial and ethnic minorities and the inadequate provision of culturally and linguistically appropriate mental health care in racial and ethnic minority communities demonstrates a clear need … to close the gap in care.".

The impact of the proposed project on existing services is expected to be negligible in light of the significant need identified, which strongly suggests a tremendous unmet need among those who are most vulnerable, those with TennCare/Medicaid coverage as well the uninsured.

The need for additional behavioral health services to serve the region has been evident at *Erlanger Health System* for some time, and the need for this project is clearly demonstrated by a detailed analysis of the service area. The defined service area is in need of an additional 219 inpatient psychiatric beds, based on the current bed need criteria.

The bed need calculation is derived from the current standard of thirty (30) beds per 100,000 population in the defined service area, less the current bed supply, to arrive at the "net need" for new psychiatric beds in the service area. The 2016 total population is 1,571,392; therefore, the bed requirement is 471 (15.71 x 30), less the current bed supply of 252, yielding a net need for new inpatient psychiatric beds of 219. The need will increase with population growth and other factors in the future.

Square Footage & Cost Per Square Foot Chart

The *Square Footage & Cost Per Square Foot Chart* is attached to this CON application.

C. As the applicant, describe your need to provide the following healthcare services (if applicable to this application):

1.	Adult Psychiatric Services	*** See Below.*
2.	Alcohol and Drug Treatment for Adolescents (exceeding 28 days)	N/A
3.	Birthing Center	N/A
4.	Burn Units	N/A
5.	Cardiac Catheterization Services	N/A
6.	Child/Adolescent Psych. Services	*** See Below.*
7.	Extracorporeal Lithotripsy	N/A
8.	Home Health Services	N/A
9.	Hospice Services	N/A
10.	Residential Hospice	N/A
11.	ICF/MR Services	N/A
12.	Long-Term Care Services	N/A
13.	Magnetic Resonance Imaging (MRI)	N/A
14.	Mental Health Residential Treatment	N/A
15.	Neonatal Intensive Care Unit	N/A
16.	Non-Residential Methadone Treatment Centers	N/A
17.	Open Heart Surgery	N/A
18.	Positron Emission Tomography	N/A
19.	Radiation Therapy/Linear Accelerator	N/A
20.	Rehabilitation Services	N/A
21.	Swing Beds	N/A

Response

Erlanger Behavioral Health seeks to add seventy-six (76) new beds to the service area. *Erlanger North Hospital* will transfer it's current complement of twelve (12) licensed geriatric psychiatric beds to *Erlanger Behavioral Health* with approval and implementation of this CON application. This will be a total of eighty-eight (88) beds in the new hospital.

Erlanger Behavioral Health will have a bed mix of twenty-four (24) Adult Psychiatric, twenty-four (24) Geriatric Psychiatric, eighteen (18) Child/Adolescent

Psychiatric and twenty-two (22) Adult Chemical Dependency beds.

In the twelve (12) month period from Oct. 1, 2014 - Sep. 30, 2015, EHS had a total of 34,853 inpatient discharges, and of that there were 11,561 discharges with a mental health condition that needed to be treated. Further, of the 11,561 discharges with a mental condition, 6,468 of those patients were admitted through the Emergency Department. As the 7th largest public health system in the nation, and the healthcare safety net for the region, *Erlanger Health System* is already the defacto provider of behavioral health services for those in need, serving those who are unable to access care elsewhere. Also, patients with cancer, cardiac or other complex medical conditions will benefit greatly from the provision of behavioral medicine provided on an outpatient basis. Having a "system of care" available to meet the needs of area residents is paramount.

Disparity in mental health status and mental health care are critical in determining the greatest need. Specifically, "Blacks, Latino's and Asian Americans are over represented in populations that are particularly at risk for mental health disorders. Additionally, minority individuals may experience symptoms that are undiagnosed, under-diagnosed, or mis-diagnosed for cultural, linguistic, or historical reasons. The lack of attention to the mental and behavioral health needs of racial and ethnic minorities and the inadequate provision of culturally and linguistically appropriate mental health care in racial and ethnic minority communities demonstrates a clear need … to close the gap in care."

The impact of the proposed project on existing services should be negligible in light of the significant need identified, which strongly suggests a tremendous unmet need among those who are most vulnerable, those with TennCare/Medicaid coverage as well the uninsured.

The need for additional behavioral health services to serve the region has been evident at *Erlanger Health System* for some time, and the need for this project is clearly demonstrated by a detailed analysis of the service area. The defined service area is in need of an additional 219 inpatient psychiatric beds, based on the current bed need criteria.

The bed need calculation is derived from the current standard of thirty (30) beds per 100,000 population in the defined service area, less the current bed supply, to arrive at the "net need" for new beds in the service area. The 2016 total population is 1,571,392; therefore, the bed requirement is 471 (15.71 x 30), less the current bed supply of 252, yielding a net need for new inpatient psychiatric beds of 219. This need will increase with population growth in the future.

D. Describe the need to change location or replace an existing facility.

Response

*** Not Applicable. ***

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $ 2.0 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. For fixed site major medical equipment (not replacing existing equipment).

   a. Describe the new equipment, including:

      1. Total Cost (as defined by Agency Rule).
      2. Expected useful life.
      3. List of clinical applications to be provided.
      4. Documentation of FDA approval.

   Response

   *** Not Applicable. ***

   b. Provide current and proposed schedules of operations.

Response

Erlanger Behavioral Health, as an inpatient acute psychiatric hospital will operate 24 hours per day, 365 days per year, along with a crisis assessment and intake center. Outpatient services will be provided Monday – Friday, 8 a.m. – 5 p.m.

2. For mobile major medical equipment:

   a. List all sites that will be served.
   b. Provide current and proposed schedules of operations.
   c. Provide the lease or contract cost.
   d. Provide the fair market value of the equipment.
   e. List the owner for the equipment.

Response

*** Not Applicable. ***

3. Indicate applicant's legal interest in equipment (i.e.-purchase, lease, etc.). In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

Response

Applicant currently has legal control of the proposed site through an Option To Purchase, a copy is attached to this CON application.

III. (A) Attach a copy of the plot plan of the site on an 8 ½" x 11" sheet of white paper which **must include**:

1. Size of site (**in acres**).

-- The *Erlanger Behavioral Health* campus is located on approximately 6.0 acres. A copy of the plot plan is attached to this CON application.

2. Location of structure on the site.

-- Please see the location of the facility on the site plan attached to this CON application.

3. Location of the proposed construction.

-- A Site Located At The Intersection Of North Holtzclaw Avenue & Citico Avenue.

4. Names of streets, roads or highways that cross or border the site.

-- Roads that border the site are *N. Holtzclaw Avenue* and *Citico Avenue*.

Please note that the drawings do not need to be drawn to scale. Plot plans are required for <u>all</u> projects.

(B) 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

<u>Response</u>

Erlanger Behavioral Health will be easily accessible to patients in Chattanooga, as well as Hamilton and surrounding counties in the service area. The new hospital can be easily accessed via public transportation. Proximal state and interstate highways provide easy access from Tennessee, Georgia, Alabama and North Carolina.

The distance from *Erlanger Medical Center* to *Erlanger Behavioral Health* is 1.1 miles, with a drive time of 2 minutes, is evidenced by the map below. Public transportation is easily accessible to the proposed location. Further, U.S. Highway 27 and U.S. Interstate 24

are major roads in downtown Chattanooga and are within 2.5 miles of the proposed location.

IV. Attach a floor plan drawing which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc., on an 8 ½" x 11" sheet of white paper.

NOTE: ***DO NOT SUBMIT BLUEPRINTS***. Simple line drawings should be submitted and need not be drawn to scale.

Response

A copy of the floor plan is attached to this CON application.

V. For a Home Health Agency or Hospice, identify:

A. Existing service area by County.
B. Proposed service area by County.
C. A parent or primary service provider.
D. Existing branches.
E. Proposed branches.

Response

*** Not applicable. ***

Section C

GENERAL CRITERIA FOR CERTIFICATE OF NEED

Section C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines For Growth), developed pursuant to Tennessee Code Annotated § 68-11-1625.

The following questions are listed according to the three (3) criteria: (1) Need, (2) Economic Feasibility, and (3) Contribution to the Orderly Development of Healthcare. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on 8 ½" x 11" white paper*. All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)".

PRINCIPLES OF TENNESSEE STATE HEALTH PLAN

[From 2011 Update, Pages 5-13]

1. *Healthy Lives*: The purpose of the State Health Plan is to improve the health of Tennesseans.

Response

Erlanger Behavioral Health will be a separately licensed affiliate of *Erlanger Health System*, and will share in the safety net mission in southeast Tennessee; though the hospital will also serve northwest Georgia, northeast Alabama and southwest North Carolina due to it's location and the scope and range of services provided. *Erlanger* is often the only health system which low-income people, minorities, and other underserved populations can turn to for treatment.

Disparity in mental health status and mental health care are critical in determining the greatest need. Specifically, "Blacks, Latino's and Asian Americans are over represented in populations that are particularly at risk for mental health disorders. Additionally, minority individuals may experience symptoms that are undiagnosed, under-diagnosed, or mis-diagnosed for cultural, linguistic, or historical reasons. The lack of attention to the mental and behavioral health needs of racial and ethnic minorities and the inadequate provision of culturally and linguistically appropriate mental health care in racial and ethnic minority communities demonstrates a clear need … to close the gap in care."

In order to assure the continued viability of its mission as a safety net hospital, *Erlanger* continually strives to provide services that are the most medically appropriate, least intensive, and provided in the most cost-effective health care setting.

As the safety net provider, a large underserved population depends on *Erlanger* to provide needed services. While it is difficult to predict the outcome of health reform initiatives, many Tennesseans previously without health insurance can be expected to elect services which may have otherwise been postponed. Surveys of the Chattanooga region have shown that some 70% or more of area physicians and surgeons received their training at *Erlanger* via its affiliation with the UT College of Medicine which is located on campus. Based on current residency and fellowship programs, it can be expected that this trend will continue with many physicians opting to remain in Tennessee, at *Erlanger*.

The proposed facility for *Erlanger Behavioral Health* is consistent with the *State Health Plan* because it seeks to ensure patient access to appropriate facilities for Tennesseans in particular. *Erlanger* is the safety net for underserved residents in southeast Tennessee, including the only Children's Hospital within 100 miles of Chattanooga, Tennessee. Providing enhanced access for those in need of care care regardless of the patients' ability to pay has been demonstrated to improve the health status of those served.

The Chattanooga region, particularly Enterprise South Industrial Park, has proven attractive to business

development due to the relatively low cost of labor, cost of living and absence of personal income tax. Also, Chattanooga has been recognized as one of the tenth lowest cost markets from a health care insurance perspective since the roll out of the *Affordable Care Act* and the insurance exchange marketplace.

Volkswagen recently announced that it will invest $600 million in its Chattanooga manufacturing plant, adding a second automobile line to its production facility. In doing so, Volkswagen expects to employ an additional 2,000 employees, with the goal to have the second production line up and running in 2016. *Erlanger* has a primary care site on the Volkswagen campus that serves employees and their families as well as others in the community. Volkswagen also has preferred employer status with *Erlanger*, whereby employees receive a discount when services are provided. With this expansion, parts, paint and other suppliers involved with the manufacturing are also expected to add employees. Volkswagen has released an additional 300 acres of property to house as many as twenty additional supply companies, increasing site employment to 7,500.

Plastic Omnium Auto Exteriors, LLC, a tier one supplier for Volkswagen, also recently announced that it will make a $65 million investment in Chattanooga, creating nearly 200 new positions at opening, with a target of 300 positions within three years. The company has purchased 27 acres in the industrial park where VW is located.

NV Michel Van De Wielke, one of the largest manufacturers of textile machines in the world indicated it would relocate to Chattanooga from Dalton, GA, to be closer to marketplace competitors and challenge rivals for market share. The plant will employ 35. Chattanooga is the birthplace of tufting with a long tradition in the flooring industry and many manufacturers are still in the region. The company will also relocate its headquarters from Charlotte, NC, to Chattanooga.

On the health front, area hospitals have also invested in plant improvements and technology. *Memorial Hospital* recently completed a renovation and expansion project of approximately $ 300 million. *Parkridge Health System*, an affiliate of *HCA Healthcare*, acquired another hospital in the region (*Grandview Hospital*) and recently completed relocation/expansion of its psychiatric facility with

approximately $ 8 million invested. *Tennova Health*, in Bradley County is owned by *Community Health System*, consolidated two facilities and invested approximately $ 45 million in upgrades.

Investment in the region is expected to continue across all industries for the foreseeable future. The Chattanooga Area Chamber of Commerce estimates that it's goal of adding more than 15,000 jobs by the end of 2015, has been met.

2. *Access To Care*: Every citizen should have reasonable access to care.

Response

Erlanger is designated by *TennCare* as the safety net hospital, for underserved residents in southeast Tennessee. *Erlanger's* TennCare / Medicaid utilization and uncompensated care cost for the last three (3) fiscal years are presented below.

	TennCare / Medicaid Utilization %	Uncompensated Care Cost
FY 2013	21.0 %	$ 85.1 M
FY 2014	22.3 %	$ 86.2 M
FY 2015	25.0 %	$ 85.1 M

Notes

(3) TennCare / Medicaid utilization percentages are based on gross I/P charges derived from applicant's internal records.

(4) Uncompensated care cost estimates were derived from applicant's internal records as reported in the notes to the annual audited financial statements.

(5) Erlanger's fiscal year begins on July 1 of each year and ends on June 30 of the following year. For example, FY 2014 began on July 1, 2013, and ended on June 30, 2014.

Erlanger clearly shoulders significantly more than its proportionate share of the care rendered to vulnerable populations. The State Health Plan favors initiatives, like the project proposed herein, which help to foster access to the underserved.

In a press release on January 28, 2016, U.S. Senator Lamar Alexander said that public legislative hearings on

the mental health crisis in America are a "priority". As evidence, Sen. Alexander cited a 2014 national study by the *Substance Abuse & Mental Health Services Administration* which found that 1 in 5 adults had a mental health condition and 9.8 million adults had serious mental illness, such as schizophrenia, bipolar disorder or depression. Of these, nearly 60% of adults with mental illness did not receive care in 2014. Only about half of adolescents with a mental health condition received treatment. Further, in a study from 2010 - 2012, nearly 21% of adults in Tennessee reported having a mental illness.

Erlanger Medical Center has the only Level I trauma center, the only life-flight helicopter service, and the only children's hospital in the region. *Erlanger* is also the only provider in its service area of Level IV neonatal care and perinatal services. *Erlanger Health System* is committed to maintaining its mission of providing healthcare services to all citizen's regardless of ability to pay. Such services include inpatient care, obstetrics, surgical services, as well as emergency and outpatient services. A clear need exists to add behavioral halth to this complement of services.

Erlanger Health System also operates several other hospitals in Southeast Tennessee, as well as a network of physician offices and *Federally Qualified Health Centers* (hereinafter "FQHC"), so that patients may easily access needed services while also facilitating easy access to the broader healthcare delivery system.

3. *Economic Efficiencies*: The State's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies, and the continued development of the state's health care system.

Response

Erlanger Behavioral Health is a new project, therefore, it does not have historical financial data upon which to base a comparative evaluation of it's services with other providers of inpatient psychiatric services. However, below is a table of other Hamilton County,

Tennessee, providers of acute psychiatric services in the service area.

Hospital	Avg. Net Revenue Per I/P Admission
Parkridge Valley-Adult Hospital	$ 11,096
Parkridge Valley-Child/Adolescent Hospital	$ 8,835
Erlanger North Hospital	$ 10,593

Notes
(1) Information derived from Tennessee Joint Annual Reports for CY 2014.

Also, the net revenue per admission for Erlanger Behavioral Health, indicated by the *Projected Data Chart*, is as follows:

	Year 1	Year 2
Admissions	1,071	2,128
Net Operating Revenue	$ 4,670,977	$ 10,951,810
Net Revenue Per Admission	$ 4,361	$ 5,146

Comparative information for *Erlanger Medical Center* and other providers is below. The inpatient net revenue per admission for local providers in Chattanooga, Tennessee, is as follows.

Hospital	Avg. Net Revenue Per I/P Admission
Erlanger Medical Center	$ 11,431
Memorial Hospital	$ 11,924
Parkridge Medical Center	$ 13,565
Erlanger East Hospital	$ 6,019
Memorial Hospital - Hixson	$ 5,671
Parkridge East Hospital	$ 7,709

Notes
(1) Information derived from Tennessee Joint Annual Reports for CY 2014.

The net revenue per admission for another CON approved project by the *Health Services & Development Agency*, is as follows:

Hospital	CON No.	Avg. Net Revenue Per I/P Admission
Crestwyn Behavioral Health	CN1310-040	$ 6,785

Evidence of Erlanger's role as a low cost provider is illustrated with the initiation of the *Health Care*

Exchanges on January 1, 2014; *Blue Network E* enrolled over 10,000 uninsured and *Erlanger* is the only provider in this network. Further, an additional 7,000 people were enrolled in *Blue Network S* and *Erlanger* is one of only two providers in this network as well. It is anticipated that these additional health networks will generate sufficient volume to keep *Erlanger* cost efficient.

While offering more complex services and capabilities, *Erlanger* has net revenue per inpatient admission lower than other large area hospitals. *Erlanger Medical Center* is economically efficient, while incurring higher costs by offering more complex services including the only Level I trauma center, the only life-flight helicopter service, the only children's hospital, the only Level I trauma center, the only Regional Perinatal Center, and the only Level IV neonatal care in southeast Tennessee.[2]

4. ***Quality Of Care*: Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.**

Response

Erlanger Health System, participates in periodic submission of quality related data to the *Centers For Medicare & Medicaid Services* through its *Hospital Compare* program and is also accredited by *The Joint Commission*. Further, *Erlanger Health System* has an internal program of *Medical Quality Improvement Committees* which continually monitor healthcare services to assure patients of the quality of care provided. The quality improvement program will include *Erlanger Behavioral Health*.

5. ***Health Care Workforce*: The state should support the development, recruitment, and retention of a sufficient and quality health care workforce.**

Response

Erlanger is an academic health system which has established strong long term relationships with the

2 Level IV as defined by the *Tennessee Perinatal Guidelines* as well as the *American College of Pediatrics.*

region's colleges, universities and clinical programs. *Erlanger* provides clinical sites for internships and rotation programs in nursing, radiology, respiratory care and pharmacy, to name a few. A number of regional universities offer Bachelor degree programs in nursing and physical therapy. Locally, two year degrees are available in many clinical allied health areas with additional programs offering advanced technical training in Radiological Imaging such as Nuclear Medicine and Diagnostic Ultrasonography.

The *University of Tennessee - College of Medicine* is co-located at Erlanger and includes training of senior medical students on clinical rotation as well as graduate medical education for training of residents and advanced fellowships in various medical specialties, including surgical specialties, as outlined below.

Residency Programs

- Emergency Medicine
- Family Medicine
- Internal Medicine
- Obstetrics & Gynecology
- Orthopedic Surgery
- Pediatrics
- Plastic Surgery
- Surgery
- Urology
- Transitional Year

Fellowship Programs

- Orthopedic Trauma Surgery
- Surgical Critical Care
- Vascular Surgery
- Colon & Rectal Surgery
- Emergency Medicine
- Neuro-Interventional Surgery
- Ultrasound
- Cardiovascular Disease
- Gastroenterology (under development)
- Radiology (under development)
- Neurology (under development)

It should be noted that *Erlanger Health System* is currently in discussions with it's academic partner, the University of Tennessee - College of Medicine, to explore

the possibility of a graduate medical education and training residency program in Psychiatry.

Further, *Erlanger Health System* also participates with numerous schools that provide advanced training in the areas of nursing and allied health.

[End Of Responses To Principles Of Tennessee State Health Plan - 2011 Update, pages 5 - 13]

PSYCHIATRIC INPATIENT SERVICES

[Standards & Criteria, Effective - 2000, p. 25-26]

A. Need

1. The population-based estimate of the total need for psychiatric inpatient services is 30 beds per 100,000 general population (using population estimates prepared by the Department of health and applying the data in Joint Annual Reports).

Response

The need for additional behavioral health services to serve the region has been evident at *Erlanger Health System* for some time, and the need for this project is clearly demonstrated by a detailed analysis of the service area. The defined service area is in need of an additional 219 inpatient psychiatric beds, based on the current bed need criteria.

Further, in the twelve (12) month period from Oct. 1, 2014 - Sep. 30, 2015, EHS had a total of 34,853 inpatient discharges, and of that there were 11,561 discharges with a mental health condition that needed to be treated. Further, of the 11,561 discharges with a mental condition, 6,468 of those patients were admitted through the Emergency Department. As such, Erlanger's emergency departments already provide mental health services to emergency patients with psychiatrists and clinical social workers.

As the 7th largest public health system in the nation, and the healthcare safety net for the region, *Erlanger Health System* is already the defacto provider of behavioral health services for those in need, serving those who are unable to access care elsewhere. Also, patients with cancer, cardiac or other complex medical conditions will benefit greatly from the provision of behavioral medicine provided on an outpatient basis. Having a "system of care" available to meet the needs of area residents is paramount.

The bed need calculation is derived from the current standard of thirty (30) beds per 100,000 population in the defined service area, less the current bed supply, to arrive at the "net need" for new beds in the service area. The 2016 total population is 1,571,392; therefore, the bed requirement is 471 (15.71 x 30), less the current bed supply of 252, yielding a net need for new inpatient psychiatric beds of 219.

Psychiatric Beds - Current Supply -- Primary, Secondary & Tertiary Service Areas

	Total Psych / SA Beds	== Total Psych / Substance Beds For Service Area == Child & Youth Beds	Adult Psych Beds	Geriatric Beds	Substance Abuse Beds	Total Beds
Parkridge Valley Hospital - Chattanooga, TN	172	108	32	16	16	172
Erlanger North Hospital - Chattanooga, TN	12			12		12
Parkridge West Hospital - Jasper, TN	20		20			20
Skyridge Medical Center - Westside - Cleveland, TN	29		29			29
Southern Tenn Med Ctr - Winchester, TN	12		12			12
Hamilton Medical Center - Dalton, GA	7		7			7
Total	252	108	100	28	16	252

(*) Bed data obtained from 2014 Tennessee *Joint Annual Reports*, *Certificate Of Need* applications, and other data sources.

	==== Pop. Est. 2016 ==== Tenn.	Non-Tenn.	== Pop. Est. 2021 === Tenn.	Non-Tenn.
Child (Age 0-14)	172,951	111,190	171,916	105,829
Adolescent (Age 15-17)	36,625	23,949	41,512	28,485
Adult (Age 18-64)	593,364	345,781	595,768	342,686
Geriatric (Age 65+)	189,726	97,806	219,645	111,282
	992,666	578,726	1,028,841	588,282
Total Est. Psychiatric Bed Need - 2016	471			
Total Est. Psychiatric Bed Need - 2021	485			

	Est. Requirement	Current Supply	Est. Need	Proposed Bed Mix
Child / Adolescent Beds - Est. Need - 2016	103	108	-5	18
Adult Beds - Est. Need - 2016	282	116	166	46
Geriatric Beds - Est. Need - 2016	86	28	58	24
Total	471	252	219	88

(**) Substance Abuse hospital beds included in Psychiatric beds.

Please note that *Moccasin Bend Mental Health Institute* ("*MBMHI*") with 150 psychiatric beds is not included in the current supply shown in the need analysis, because this facility is a State funded psychiatric hospital and serves a totally different clientele than will *Erlanger Behavioral Health*. As noted on the MBMHI website, the mission of *MBMHI* is identified as:

> "The mission of *MBMHI* is to provide quality psychiatric services to individuals with a severe and persistent mental illness."

Further, *MBMHI* has two (2) units which are reserved for treatment of long-term care mental health patients, which is significantly different than the focus for *Erlanger*

Behavioral Health. Because *MBMHI* treats those who are severely and persistently mentally ill, it is not expected that this project will impact it's services as that target patient population is .

There are currently a total of five (5) provider organizations delivering inpatient psychiatric and substance abuse/chemical dependency services at a total of seven (7) locations within the defined service area, for a total of 252 licensed inpatient beds.

Erlanger Behavioral Health will have a bed mix of twenty-four (24) Adult Psychiatric, twenty-four (24) Geriatric Psychiatric, eighteen (18) Child/Adolescent Psychiatric and twenty-two (22) Adult Chemical Dependency beds.

Erlanger Behavioral Health seeks to add seventy-six (76) new beds to the service area. *Erlanger North Hospital* will transfer it's current complement of twelve (12) licensed geriatric psychiatric beds to *Erlanger Behavioral Health* with approval and implementation of this CON application. This will be a total of eighty-eight (88) beds.

In a press release on January 28, 2016, U.S. Senator Lamar Alexander said that public legislative hearings on the mental health crisis in America are a "priority". As evidence, Sen. Alexander cited a 2014 national study by the *Substance Abuse & Mental Health Services Administration* which found that 1 in 5 adults had a mental health condition and 9.8 million adults had serious mental illness, such as schizophrenia, bipolar disorder or depression. Of these, nearly 60% of adults with mental illness did not receive care in 2014. Only about half of adolescents with a mental health condition received treatment. Further, in a study from 2010 - 2012, nearly 21% of adults in Tennessee reported having a mental illness.

In short, there is a critical need for additional inpatient psychiatric beds from the community need perspective, as well as *Erlanger's* institutional need perspective.

2. For adult programs, the age group of 18 years

and older should be used in calculating the estimated total number of beds needed.

Response

As illustrated by the need information presented in item A-1, the bed need for adults is calculated based on the age group 18-64 years, and the geriatric need is calculated based on the age group over 65. Based on this methodology, the service area has a demonstrated need for adults of 166 additional beds, and the demonstrated need for geriatric is an additional 58 beds.

Erlanger Behavioral Health will have a bed mix of twenty-four (24) Adult Psychiatric, twenty-four (24) Geriatric Psychiatric, eighteen (18) Child/Adolescent Psychiatric and twenty-two (22) Adult Chemical Dependency beds.

3. **For child inpatient under age 13, and if adolescent program the age group of 13-17 should be used.**

Response

As illustrated by the need information presented in item A-1, the bed need for child/adolescents is calculated based on the age group 0-17 years.

Erlanger Behavioral Health will have a bed mix of eighteen (18) child/adolescent beds.

4. **These estimates for total need should be adjusted by the existing staffed beds operating in the area as counted by the Department of Health in the Joint Annual Report.**

Response

As illustrated by the need information presented in item A-1, the bed need has been adjusted by the existing staffed beds operating in the service area, as reported in the 2014 Tennessee Joint Annual Reports for hospitals.

B. Service Area

1. The geographic service area should be reasonable and based on an optimal balance between population density and service proximity or the Community Service Agency.

Response

The service area for this project is defined as Hamilton County, Tennessee, and the counties that surround Hamilton County in Tennessee, Georgia, Alabama and North Carolina. The service area consists of a total of thirty (30) contiguous counties in the four (4) state geography. A complete list of the counties which comprise the service area is attached to this CON application.

This geography represents the primary, secondary and tertiary service areas for *Erlanger Medical Center*. As such, the service area is reasonable and provides optimal balance between population density and service proximity.

2. The relationship of the socio-demographics of the service area, and the projected population to receive services, should be considered. The proposal's sensitivity to, and responsiveness to the special needs of the service area should be considered including accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, and those needing services involuntarily.

Response

Erlanger Behavioral Health will serve adolescents and adults of all ages without discrimination, and also without regard to gender, ethnicity or ability to pay for services.

Erlanger Behavioral Health will serve all patients in need of psychiatric and substance abuse services regardless of ability to pay. Further, patients with TennCare/Medicaid coverage will be admitted and served, as will charity patients.

Erlanger Behavioral Health will accept involuntary admissions from the judicial system regardless of ability to pay.

C. Relationship To Existing Applicable Plans

1. The proposal's relationship to policy as formulated in state, city, county, and/or regional plans and other documents should be a significant consideration.

Response

The *Tennessee Guidelines For Growth*, which have already been addressed, identify several factors pertaining to this CON application. The *Guidelines* support delivery of services in the most medically appropriate setting, which goal this CON application serves. The *Guidelines* support those CON applications which provide services to the elderly, which goal this CON application serves. The *Guidelines* indicate that preference will be given to patient accessibility and availability, which goal this CON application serves.

According to the *Tennessee State Health Plan* "mental health problems are more prevalent in Tennessee than the national average", while "the prevalence of mental health problems and illnesses is often underestimated" … but "despite improvements in our understanding of mental health problems and illnesses often do not get treatment".[3] This CON application seeks to serve this significant need.

2. The proposal's relationship to underserved geographic areas as identified in state, city, county and/or regional plans and other documents should be a significant consideration.

Response

The extensive service area extends from Chattanooga across rural parts of four (4) States, and includes numerous counties which are designated by the *Health Resources & Services Administration* as *Medically*

3 *Tennessee State Health Plan*, November, 2009, page 25.

Underserved Areas ("MUA's"). The medically underserved area includes Chattanooga and Hamilton County, Tennessee. Further, every county in the defined service area is classified as a *Health Professional Shortage Area* ("HPSA") for mental health, and this also includes Chattanooga and Hamilton County, Tennessee.

3. The impact of the proposal on similar services supported by state appropriations should be assessed and considered.

Response

It is noted that *Moccasin Bend Mental Health Institute* ("MBMHI") is a State funded psychiatric hospital in Chattanooga, Hamilton County, Tennessee. However, this project is not expected to have any impact on *MBMHI* due to the nature of the patients which this provider accepts. From the website, the mission of *MBMHI* is identified as:

> "The mission of *MBMHI* is to provide quality psychiatric services to individuals with a severe and persistent mental illness."

Also, *MBMHI's* service area is also much broader than the service area proposed. The *MBMHI* service area is 52 counties which serves all of East Tennessee extending North to the Kentucky and Virginia state lines.

MBMHI has a total of 150 acute psychiatric beds, which includes two (2) long term care units. Further, MBMHI identifies it's service area as fifty-two (52) counties in East Tennessee, this includes thirty-four (34) counties in Tennessee that are not in the service area for *Erlanger Behavioral Health*. Because *MBMHI* treats those who are severely mentally ill, it is not expected that this project will impact it's services.

4. The proposal's relationship to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility serves acute and/or long-term patients, should be assessed and considered.

Response

As stated in response to item B-2, *Erlanger Behavioral Health* will accept voluntary patients, as well as involuntary patients from the judicial system. Acute mental health patients will be served at this facility, not long-term patients on a residential basis.

5. The degree of projected financial participation in the Medicare and TennCare programs should be considered.

Response

As stated in response to item B-2, *Erlanger Behavioral Health* will participate in both the Medicare and TennCare programs.

D. Relationship To Existing Similar Services In The Area

1. The area's trends in occupancy and utilization of similar services should be considered.

Response

The utilization trend for psychiatric and substance abuse beds is presented below. Utilization for CY 2014 suggests that not all populations including special needs, are receiving these necessary services.

Psychiatric Beds - Utilization Trend						
			========= Actual Discharges =========			
			2014	2013	2012	2011
Parkridge Valley Adult - Chattanooga, TN			2,070	-	-	-
Parkridge Valley Child/Adolescent - Chattanooga, TN			1,211	3,004	3,073	3,106
Parkridge Medical Center - Chattanooga, TN			-	-	258	291
Erlanger North Hospital - Chattanooga, TN			262	281	268	56
Parkridge West Hospital - Jasper, TN			497	465	473	163
Skyridge Medical Center - Westside - Cleveland, TN			840	928	959	843
Southern Tenn Med Ctr - Winchester, TN			170	86	135	146
Hamilton Medical Center - Dalton, GA						
Total			5,050	4,764	5,166	4,605
	Total Psych / SA Beds	Annual Pt. Days Available	======= Actual Patient Days =========			
			2014	2013	2012	2011
Parkridge Valley Adult - Chattanooga, TN	64	23,360	12,420	-	-	-
Parkridge Valley Child/Adolescent - Chattanooga, TN	108	39,420	30,203	44,968	39,153	39,012
Parkridge Medical Center - Chattanooga, TN	11	4,015	-	-	2,793	3,054
Erlanger North Hospital - Chattanooga, TN	12	4,380	3,628	3,761	3,746	3,692
Parkridge West Hospital - Jasper, TN	20	7,300	4,930	5,055	5,278	1,527
Skyridge Medical Center - Westside - Cleveland, TN	29	10,585	2,203	1,038	1,362	1,567
Southern Tenn Med Ctr - Winchester, TN	12	4,380	4,170	3,916	4,421	4,448
Hamilton Medical Center - Dalton, GA	7					
Total	263	93,440	57,554	58,738	56,753	53,300
			========= Occupancy Rate ==========			
			2014	2013	2012	2012
Parkridge Valley Adult - Chattanooga, TN			53.2%	-	-	-
Parkridge Valley Child/Adolescent - Chattanooga, TN			76.6%	114.1%	99.3%	99.0%
Parkridge Medical Center - Chattanooga, TN			-	-	69.6%	76.1%
Erlanger North Hospital - Chattanooga, TN			82.8%	85.9%	85.5%	84.3%
Parkridge West Hospital - Jasper, TN			67.5%	69.2%	72.3%	20.9%
Skyridge Medical Center - Westside - Cleveland, TN			20.8%	9.8%	12.9%	14.8%
Southern Tenn Med Ctr - Winchester, TN			95.2%	89.4%	100.9%	101.6%
	NOTES					
	(1) Utilization data obtained from Tennessee *Joint Annual Reports*.					
	(2) Parkridge Valley moved it's Adult & Geriatric beds to a new campus in 2014.					
	(3) Utilization data not available for Hamilton Medical Center in Dalton, Georgia.					

Nationally, utilization of Psychiatric services is expected to increase over the next ten (10) years between 2015 and 2025, with overall growth for inpatient service at a rate of 5% and overall growth for outpatient service at a rate of 19%. Sg2, a national healthcare consultancy firm, provides the following detail by growth factor:

Factor	Inpatient	Outpatient
Population	7%	8%
Epidemiology	1%	3%
Economy	.5%	1%
Policy	.2%	1%
Innovation & Tech.	-2%	1%

System Of Care	-2%	4%
Total	5%	19%

Notes
(1) Information obtained from Sg2, *2015 Behavioral Health Landscape - Introduction To The Forecast*, p. 6.

In addition, Sg2 estimates that 68% of those with a mental disorder also have 1 or more medical conditions. Further, 29% of adults with a chronic condition have a comorbid mental health disorder.

2. Accessibility to specific special need groups should be an important factor.

Response

Erlanger Behavioral Health will serve adolescents and adults of all ages without discrimination, and also without regard to gender, ethnicity or ability to pay for services.

Disparity in mental health status and mental health care are critical in determining the greatest need. Specifically, "Blacks, Latino's and Asian Americans are over represented in populations that are particularly at risk for mental health disorders. Additionally, minority individuals may experience symptoms that are undiagnosed, under-diagnosed, or mis-diagnosed for cultural, linguistic, or historical reasons. The lack of attention to the mental and behavioral health needs of racial and ethnic minorities and the inadequate provision of culturally and linguistically appropriate mental health care in racial and ethnic minority communities demonstrates a clear need … to close the gap in care."

Erlanger Behavioral Health will serve all patients in need of psychiatric and substance abuse services regardless of ability to pay. Further, patients with TennCare/Medicaid coverage will be admitted and served, as will charity patients.

Erlanger Behavioral Health will accept involuntary admissions from the judicial system regardless of ability to pay.

E. Feasibility

The ability of the applicant to meet Tennessee Department of Mental Health licensure requirements (related to personnel and staffing for psychiatric inpatient facilities) should be considered.

Response

Erlanger Behavioral Health will meet all licensure requirements of the *Tennessee Department of Mental Health* related to personnel and staffing for inpatient psychiatric hospitals.

[End Of Responses To Standards & Criteria For Psychiatric Inpatient Services, 2000, page 26-26]

GENERAL QUESTIONS CONCERNING NEED, ECONOMIC FEASIBILITY & CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE

(I.) *NEED*

1. Describe the relationship of this proposal toward the implementation of the State Health Plan, Teneessee's Health: Guidelines For Growth.

(a) Please provide a response to each criterion and standard in Certificate Of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.

Response

This project is consistent with the *Principles Of The Tennessee State Health Plan* as stated in the 2011 update ("Principles"). *Applicant* has addressed each of the Principles.

(b) Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c).

Response

** Not applicable. **

2. Describe the relationship of this proposal to the applicant facility's long range development plans, if any.

Response

Erlanger Health System currently holds a CON for expansion of *Erlanger East Hospital* (No. CN0405-047AE); and a CON to modernize and upgrade the surgical facilities at *Erlanger Medical Center* (No. CN1207-034A); a CON was approved for *Erlanger East Hospital* to initiate a satellite radiation therapy service along with the relocation of a Linear Accelerator from *Erlanger Medical Center* (no. CN1412-048); a CON application was approved to upgrade the Cardiac Catheterization Laboratory for *Erlanger East Hospital* from a diagnostic catheterization laboratory to an interventional / therapeutic laboratory (No. CN1502-005). Also, a CON application (No. CN1601-002) is currently pending with the *Health Services & Development Agency* to add a Level III NICU at *Erlanger East Hospital*.

The goal for *Erlanger Health System* is to provide a comprehensive system of care comprised of unduplicated services while also serving those who are currently under served and/or those who do not have the ability to pay for their services. As such, *Erlanger Behavioral Health* is part of a long term plan to make services more accessible.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. Please submit maps on 8 ½" x 11" sheets of white paper marked only with ink detectable by a standard photocopier (i.e-no highlighters, pencils, etc.).

Response

The service area for this project is defined as Hamilton County, Tennessee, and the counties that surround Hamilton County in Tennessee, Georgia, Alabama and North Carolina. The service area consists of a total of thirty (30) contiguous counties in the four (4) state geography. A complete list of the counties which comprise the service area is attached to this CON application.

This geography represents the same primary, secondary and tertiary service areas as *Erlanger Medical Center*. Therefore, the service area is reasonable and provides balance between population density and service proximity. A map showing the service area is attached to this CON application.

4. A. Describe the demographics of the population to be served by this proposal.

Response

The State of Tennessee has a TennCare enrollment of 20.0%, compared to the Tennessee service area for this project which is 21.7%. The population over age 65 is expected to grow by 6.8% for the service area between 2016 and 2020, compared to the Tennessee growth rate of 3.2% … while the total population is expected to grow by only 3.0% for the service area, compared to 3.7% for Tennessee. Briefly stated, this illustrates that the over 65 population is growing at a faster rate than the total population for the Tennessee service area, when compared to the State of Tennessee.

The need for additional behavioral health services to serve the region has been evident at *Erlanger Health System* for some time, and the need for this project is clearly demonstrated by a detailed analysis of the service area. The defined service area is in need of an additional 219 inpatient psychiatric beds, based on the current bed need criteria.

In the twelve (12) month period from Oct. 1, 2014 - Sep. 30, 2015, EHS had a total of 34,853 inpatient discharges, and of that there were 11,561 discharges with a mental health condition that needed to be treated.

Further, of the 11,561 discharges with a mental condition, 6,468 of those patients were admitted through the Emergency Department. As the 7th largest public health system in the nation, and the healthcare safety net for the region, *Erlanger Health System* is already the defacto provider of behavioral health services for those in need, serving those who are unable to access care elsewhere. Also, patients with cancer, cardiac or other complex medical conditions will benefit greatly from the provision of behavioral medicine provided on an outpatient basis. Having a "system of care" available to meet the needs of area residents is paramount.

A summary of demographic information appears below which outlines TennCare enrollment, changes in population, and that portion which is below the Federal poverty level within the service area, by county compared to the State of Tennessee.

	Hamilton	Bradley	Marion	Grundy	Sequatchie	Bledsoe		
Current Year (2016) - Age 65+	61,073	17,879	5,763	3,021	3,195	2,628		
Projected Year (2020 - Age 65+	69,752	20,381	6,584	3,339	3,896	2,955		
Age 65+ - % Change	14.2%	14.0%	14.2%	10.5%	21.9%	12.4%		
Age 65+ - % Total	17.1%	16.9%	20.2%	22.4%	20.2%	19.8%		
Total Pop. - 2016	356,156	105,549	28,585	13,470	15,835	13,273		
Total Pop. - 2020	368,666	109,706	28,633	13,263	16,943	13,481		
Total Pop. - % Change	3.5%	3.9%	0.2%	-1.5%	7.0%	1.6%		
Median Age	39	38	42	41	41	42		
Median Household Income	$46,702	$41,083	$41,268	$26,814	$36,434	$33,443		
TennCare Enrollees	61,399	20,321	6,636	4,626	3,716	3,082		
TennCare Enrollees As % Of Total Pop.	17.2%	19.3%	23.2%	34.3%	23.5%	23.2%		
Persons Below Poverty Level	59,979	20,664	5,215	3,957	2,653	2,825		
Persons Below Poverty Level As % Of Total Pop.	16.8%	19.6%	18.2%	29.4%	16.8%	21.3%		

	Rhea	Meigs	McMinn	Polk	Franklin	Coffee		
Current Year (2016) - Age 65+	6,589	2,677	11,089	3,680	8,752	10,225		
Projected Year (2020 - Age 65+	7,571	3,151	12,650	4,134	9,972	11,573		
Age 65+ - % Change	14.9%	17.7%	14.1%	12.3%	13.9%	13.2%		
Age 65+ - % Total	19.4%	21.9%	20.4%	21.1%	20.8%	18.3%		
Total Pop. - 2016	33,934	12,221	54,449	17,442	42,097	55,932		
Total Pop. - 2020	35,216	12,462	55,724	17,812	42,681	57,865		
Total Pop. - % Change	3.8%	2.0%	2.3%	2.1%	1.4%	3.5%		
Median Age	40	43	42	43	41	40		
Median Household Income	$36,741	$35,150	$39,410	$39,074	$42,904	$37,618		
TennCare Enrollees	8,490	2,907	11,270	3,784	7,166	12,252		
TennCare Enrollees As % Of Total Pop.	25.0%	23.8%	20.7%	21.7%	17.0%	21.9%		
Persons Below Poverty Level	7,631	2,553	9,786	2,867	6,250	11,457		
Persons Below Poverty Level As % Of Total Pop.	22.5%	20.9%	18.0%	16.4%	14.8%	20.5%		

	Warren	Van Buren	Monroe	Cumberland	Loudon	Roane	Service Area	State Of Tennessee
Current Year (2016) - Age 65+	7,350	1,313	10,398	19,871	15,089	12,670	203,262	1,012,937
Projected Year (2020 - Age 65+	8,233	1,554	12,384	23,106	17,908	14,509	233,652	1,134,565
Age 65+ - % Change	12.0%	18.4%	19.1%	16.3%	18.7%	14.5%	15.0%	12.0%
Age 65+ - % Total	100.0%	100.0%	100.0%	33.9%	29.0%	24.2%	21.8%	15.2%
Total Pop. - 2016	7,350	1,313	10,398	58,566	51,988	52,300	930,858	6,649,438
Total Pop. - 2020	8,233	1,554	12,384	60,368	52,245	51,602	958,838	6,894,997
Total Pop. - % Change	12.0%	18.4%	19.1%	3.1%	0.5%	-1.3%	3.0%	3.7%
Median Age	39	45	42	50	48	48	42	38
Median Household Income	$34,641	$33,547	$37,595	$39,901	$53,815	$49,949	$45,482	$44,298
TennCare Enrollees	10,217	1,242	10,881	12,934	9,187	11,789	201,899	1,331,838
TennCare Enrollees As % Of Total Pop.	139.0%	94.6%	104.6%	22.1%	17.7%	22.5%	21.7%	20.0%
Persons Below Poverty Level	8,742	1,222	9,126	9,721	7,070	9,414	181,132	1,170,301
Persons Below Poverty Level As % Of Total Pop.	118.9%	93.1%	87.8%	16.6%	13.6%	18.0%	19.5%	17.6%

B. The special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Response

As a member facility of *Erlanger Health System*, *Erlanger Behavioral Health* is a component of the safety net

for southeast Tennessee. Often the only hospital which low-income people, minorities, and other underserved populations can turn to for treatment is *Erlanger*. In order to assure the continued viability of its mission as the safety net provider, *Erlanger Health System* continually strives to provide services that are medically appropriate, least intensive (restrictive), and provided in the most cost-effective health care setting.

Disparity in mental health status and mental health care are critical in determining the greatest need. Specifically, "Blacks, Latino's and Asian Americans are over represented in populations that are particularly at risk for mental health disorders. Additionally, minority individuals may experience symptoms that are undiagnosed, under-diagnosed, or mis-diagnosed for cultural, linguistic, or historical reasons. The lack of attention to the mental and behavioral health needs of racial and ethnic minorities and the inadequate provision of culturally and linguistically appropriate mental health care in racial and ethnic minority communities demonstrates a clear need … to close the gap in care."

Erlanger Behavioral Health is easily accessible to patients in Chattanooga, as well as Hamilton and surrounding counties in the service area. The hospital can be easily accessed via public transportation. Proximal state and interstate highways provide easy access from Tennessee, Georgia, Alabama and North Carolina.

The distance from *Erlanger Medical Center* to *Erlanger Behavioral Health* is 1.1 miles, with a drive time of 2 minutes, as evidenced by the map below. Public transportation is easily accessible to the proposed location. Further, U.S. Highway 27 and U.S. Interstate 24 are major roads in downtown Chattanooga and are within 2.5 miles of the proposed location.

Erlanger has also been responsive to the needs of employees and families of new businesses like VW, Amazon and Wacker Chemical which have generated thousands of new jobs in the area. The proposed project will help ensure that the service area population have access to services and facilities consistent with their needs and evolving industry standards.

5. Describe the existing or certified services, including approved but unimplemented CON's, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utlilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

Response

There are currently no outstanding CON's for inpatient psychiatric facilities in the service area. The utilization trend for psychiatric and substance abuse beds suggests that not all populations, including special needs, are receiving these necessary services.

Psychiatric Beds - Utilization Trend

	Total Psych / SA Beds	Annual Pt. Days Available	Actual Discharges 2014	2013	2012	2011
Parkridge Valley Adult - Chattanooga, TN			2,070	-	-	-
Parkridge Valley Child/Adolescent - Chattanooga, TN			1,211	3,004	3,073	3,106
Parkridge Medical Center - Chattanooga, TN			-	-	258	291
Erlanger North Hospital - Chattanooga, TN			262	281	268	56
Parkridge West Hospital - Jasper, TN			497	465	473	163
Skyridge Medical Center - Westside - Cleveland, TN			840	928	959	843
Southern Tenn Med Ctr - Winchester, TN			170	86	135	146
Hamilton Medical Center - Dalton, GA						
Total			5,050	4,764	5,166	4,605
	Total Psych / SA Beds	**Annual Pt. Days Available**	**Actual Patient Days 2014**	**2013**	**2012**	**2011**
Parkridge Valley Adult - Chattanooga, TN	64	23,360	12,420	-	-	-
Parkridge Valley Child/Adolescent - Chattanooga, TN	108	39,420	30,203	44,968	39,153	39,012
Parkridge Medical Center - Chattanooga, TN	11	4,015	-	-	2,793	3,054
Erlanger North Hospital - Chattanooga, TN	12	4,380	3,628	3,761	3,746	3,692
Parkridge West Hospital - Jasper, TN	20	7,300	4,930	5,055	5,278	1,527
Skyridge Medical Center - Westside - Cleveland, TN	29	10,585	2,203	1,038	1,362	1,567
Southern Tenn Med Ctr - Winchester, TN	12	4,380	4,170	3,916	4,421	4,448
Hamilton Medical Center - Dalton, GA	7					
Total	263	93,440	57,554	58,738	56,753	53,300
			Occupancy Rate 2014	**2013**	**2012**	**2012**
Parkridge Valley Adult - Chattanooga, TN			53.2%	-	-	-
Parkridge Valley Child/Adolescent - Chattanooga, TN			76.6%	114.1%	99.3%	99.0%
Parkridge Medical Center - Chattanooga, TN			-	-	69.6%	76.1%
Erlanger North Hospital - Chattanooga, TN			82.8%	85.9%	85.5%	84.3%
Parkridge West Hospital - Jasper, TN			67.5%	69.2%	72.3%	20.9%
Skyridge Medical Center - Westside - Cleveland, TN			20.8%	9.8%	12.9%	14.8%
Southern Tenn Med Ctr - Winchester, TN			95.2%	89.4%	100.9%	101.6%

NOTES

(1) Utilization data obtained from Tennessee *Joint Annual Reports*.

(2) Parkridge Valley moved it's Adult & Geriatric beds to a new campus in 2014.

(3) Utilization data not available for Hamilton Medical Center in Dalton, Georgia.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.

Response

As a new facility, *Erlanger Behavioral Health* does not have historical utilization data to report, however, projected utilization data is presented below.

	Year 1	Year 2
Admissions	1,071	2,128
Patient Days	8,798	17,481
Average Daily Census	24.1	47.9

(II.) *ECONOMIC FEASIBILITY*

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

- **All projects should have a project cost of at least $ 3,000 on Line F (minimum CON filing fee). CON filing fee should be calculated from Line D. (See application instructions for filing fee.)**

- **The cost of any lease should be based on fair market value or the total amount of lease payments over the initial term of the lease, whichever is greater.**

- **The cost of fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.**

- **For projects that include new construction, modification, and/or renovation; documentation must be provided from a contractor and/or architect that support the estimated construction costs.**

Response

The *Project Cost Chart* has been completed on the next page.

PROJECT COST CHART

A.	Construction And Equipment Acquired By Purchase.		
1.	Architecural And Engineering Fees		1,632,600
2.	Legal, Administrative, Consultant Fees (Excluding CON Filing Fees)		50,000
3.	Acquisition Of Site		825,000
4.	Preparation Of Site		1,800,000
5.	Construction Costs		18,720,000
6.	Contingency Fund		1,000,000
7.	Fixed Equipment (Not Included In Construction Contract)		350,000
8.	Moveable Equipment (List all equipment over $ 50,000)		
9.	Other (Specify) Dietary equipment & misc. start-up costs.		690,000
B.	Acquisition By Gift, Donation, Or Lease.		
1.	Facility (inclusive of building and land)		0
2.	Building Only		0
3.	Land Only		0
4.	Equipment (Specify) _____		0
5.	Other (Specify) _____		0
C.	Financing Costs And Fees.		
1.	Interim Financing		0
2.	Underwriting Costs		0
3.	Reserve For One Year's Debt Service		0
4.	Other (Specify) _____		0
D.	Estimated Project Cost	(A + B + C)	24,067,600
E.	CON Filing Fee		45,000
F.	Total Estimated Project Cost	(D + E)	25,112,600

2. Identify the funding sources for this project.

a. Please check the applicable item(s) below and briefly summarize how the project will be financed. (Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)

___ A. Commercial Loan -- Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions.

___ B. Tax - Exempt Bonds -- Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance.

___ C. General obligation bonds -- Copy of resolution from issuing authority or minutes from the appropriate meeting.

___ D. Grants -- Notification of intent form for grant application or notice of grant award.

___ E. Cash Reserves - Appropriate documentation from Chief Financial Officer.

_X_ F. Other - Identify and document funding from all other sources.

Response

The project will be funded by *Acadia Healthcare*. See letter attached to this CON application.

3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services And Development Agency.

Response

Cost per square foot for hospital construction is shown below for HSDA approved projects from 2012 - 2014.

HSDA -- Hospital Construction Cost Per Square Foot Approved Projects -- 2012 - 2014			
	Renovated Construction	New Construction	Total Construction
1st Quartile	$ 110.98 / SF	$ 224.09 / SF	$ 156.78 / SF
Median	$ 192.46 / SF	$ 259.56 / SF	$ 227.88 / SF
3rd Quartile	$ 297.82 / SF	$ 296.52 / SF	$ 298.66 / SF

An analysis of the cost per square foot with similar projects in Tennessee is below.

Facility	CON Number	Cost Per Square Foot
Crestwyn Behavioral Health	CN1310-040	$ 244.85
SBH-Kingsport, LLC	CN1312-050	$ 153.00

The construction cost of $ 18,720,000 for this project, along with the estimated 69,000 SF, will yield cost estimate per SF for the *Erlanger Behavioral Health* facility of $ 271.30. This cost is reasonable when compared to the projects above, particularly when considered in relation to time and location.

4. Complete Historical and Projected Data Charts on the following two pages - *Do not modify the Charts provided or submit Chart substitutions* ! Historical Data Chart represents revenue and expense information for the last *three* (3) years for which complete information is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the *Proposal Only* (i.e.-if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).

Response

Please note that since *Erlanger Behavioral Health* is a new hospital, there is no historical financial information to report. However, we have provided the historical financial information for *Erlanger Health System*. The *Historical Data Chart* and *Projected Data Chart* have been completed. The detail for *Other Expenses* on the *Historical Data Chart* is attached to this CON application.

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in ___July___ (Month).

		Year – 2013	Year – 2014	Year – 2015
A.	Utilization Data	29,066	30,394	33,340
	(Specify Unit Of Measure) I/P Admits			
B.	Revenue From Services To Patients			
	1. Inpatient Services	951,407,744	1,011,698,242	1,182,962,344
	2. Outpatient Services	638,832,332	723,658,840	830,030,436
	3. Emergency Services	122,125,184	147,183,286	171,845,957
	4. Other Operating Revenue	33,499,831	36,036,026	32,126,111
	(Specify) Home Health, POB Rent, etc.			
	Gross Operating Revenue	1,745,865,091	1,918,576,394	2,216,964,846
C.	Deductions From Operating Revenue			
	1. Contractual Adjustments	997,920,752	1,105,607,716	1,317,441,010
	2. Provision For Charity Care	102,150,881	110,213,778	92,392,901
	3. Provision For Bad Debt	74,808,470	84,222,955	93,878,274
	Total Deductions	1,174,880,103	1,300,044,449	1,503,712,185
	NET OPERATING REVENUE	570,984,988	618,531,945	713,252,663
D.	Operating Expenses			
	1. Salaries And Wages	275,109,764	276,229,682	270,118,412
	2. Physician's Salaries And Wages	36,117,461	42,290,749	76,375,201
	3. Supplies	78,028,042	82,925,430	93,104,628
	4. Taxes	536,994	566,101	558,754
	5. Depreciation	27,373,556	26,732,222	25,647,102
	6. Rent	5,341,116	5,209,326	5,816,951
	7. Interest – Other Than Capital	0	0	0
	8. Management Fees:			
	a. Fees To Affiliates			
	b. Fees To Non-Affiliates			
	9. Other Expenses	156,440,656	166,565,645	193,745,905
	(Specify) Insurance, Purch. Svcs., etc.			
	Total Operating Expenses	578,947,589	600,519,155	665,366,953
E.	Other Revenue (Expenses) - Net			
	(Specify) _____			
	NET OPERATING INCOME (LOSS)	(7,962,601)	18,012,789	47,885,710
F.	Capital Expenditures			
	1. Retirement Of Principal	7,900,842	8,048,272	15,492,190
	2. Interest	8,971,728	8,258,717	9,507,644
	Total Capital Expenditures	16,872,570	16,306,989	24,999,834
	NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	(24,835,171)	1,705,800	22,885,876

PROJECTED DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in ___July____ (Month).

		Year 1	Year 2
A.	Utilization Data	8,798	17,481
	(Specify Unit Of Measure) Pt. Days		
B.	Revenue From Services To Patients		
	1. Inpatient Services	11,870,450	26,516,061
	2. Outpatient Services	121,350	339,270
	3. Emergency Services	-	-
	4. Other Operating Revenue	10,000	12,000
	Gross Operating Revenue	12,001,800	26,867,331
C.	Deductions From Operating Revenue		
	1. Contractual Adjustments	6,727,381	15,027,536
	2. Provision For Charity Care		
	3. Provision For Bad Debt	603,442	887,985
	Total Deductions	7,330,823	15,915,521
	NET OPERATING REVENUE	4,670,977	10,951,810
D.	Operating Expenses		
	1. Salaries And Wages	3,432,825	6,124,604
	2. Physician's Salaries And Wages	172,335	314,512
	3. Supplies	319,545	483,451
	4. Taxes		
	5. Depreciation	812,831	841,574
	6. Rent	24,000	24,720
	7. Interest - Other Than Capital		
	8. Management Fees:		
	a. Fees To Affiliates		
	b. Fees To Non-Affiliates		
	9. Other Expenses	1,121,362	3,048,512
	(Specify) Service Contracts		
	Total Operating Expenses	5,882,898	10,837,373
E.	Other Revenue (Expenses) – Net		
	(Specify) _____		
	NET OPERATING INCOME (LOSS)	(1,211,921)	114,438
F.	Capital Expenditures		
	1. Retirement Of Principal		
	2. Interest		
	Total Capital Expenditures		
	NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	(1,211,921)	114,438

5. **Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.**

Response

Following are the average charge amounts per patient.

Average Gross Charge	$ 11,206
Average Deduction From Revenue	$ 6,845
Average Net Revenue	$ 4,361
Average Deduction From Revenue	
Medicare	$ 7,759
TennCare / Medicaid	$ 12,820
Average Net Revenue	
Medicare	$ 7,759
TennCare / Medicaid	$ 7,422

6. A. **Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges of projects that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.**

Response

A charge master file for *Erlanger Behavioral Health* has not yet been developed. However, net revenue per admission as indicated by the *Projected Data Chart* is as follows:

	Year 1	Year 2
Admissions	1,071	2,128
Net Operating Revenue	$ 4,670,977	$ 10,951,810
Net Revenue Per Admission	4,361	$ 5,146

It is anticipated that *Erlanger Behavioral Health* will revise it's charges annually once it opens for operation. Generally, proposed charges will be in line with other like providers.

B. **Compare the proposed charges to those of other**

facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services And Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response

Erlanger Behavioral Health does not have any historical financial data upon which to base a comparative evaluation of it's services with other providers of inpatient psychiatric services. However, below is a table of other Hamilton County, Tennessee, providers of acute psychiatric services in the service area.

Hospital	Avg. Net Revenue Per I/P Admission
Parkridge Valley-Adult Hospital	$ 11,096
Parkridge Valley-Child/Adolescent Hospital	$ 8,835
Erlanger North Hospital	$ 10,593

Notes
(1) Information derived from Tennessee Joint Annual Reports for CY 2014.

Also, the net revenue per admission for the new hospital, indicated by the *Projected Data Chart*, is as follows:

	Year 1	Year 2
Admissions	1,071	2,128
Net Operating Revenue	$ 4,670,977	$ 10,951,810
Net Revenue Per Admission	$ 4,361	$ 5,146

The net revenue per admission for another CON approved project by the *Health Services & Development Agency*, is as follows:

Hospital	CON No.	Avg. Net Revenue Per I/P Admission
Crestwyn Behavioral Health	CN1310-040	$ 6,785

7. Discuss how projected utilization rates will be sufficient to maintain cost effectiveness.

Response

Despite the significant need demonstrated in this CON application, *Erlanger Behavioral Health* has been conservative by estimating an average daily census of 24.1 in year 1 of the project, and an average daily census of 47.9 in year 2. As the *Projected Data Chart* demonstrates, a positive financial result will be achieved beginning in year 2. As the average daily census increases over subsequent years, the efficiency gained by higher utilization will enable cost effectiveness to be sustained.

8. Discuss how financial viability will be ensured within two (2) years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.

Response

As demonstrated by the *Projected Data Chart*, the project has a positive financial result beginning in year 2 of the project. Year 1 financial results reflect start-up costs. For example, year 1 includes 10 months of revenue but 12 months of expense for training and onboarding of new staff members during start-up.

9. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

Response

Erlanger Behavioral Health, will apply to CMS for participation in the following Federal / State programs.

Federal	Medicare
State	BlueCare
	TennCare Select
	AmeriGroup Community Care

Anticipated revenue (gross charges) from Federal and State sources during year 1 of the project, is as follows.

Medicare	$ 3,917,249
TennCare	$ 3,086,317
	$ 7,003,566

10. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.

Response

Please note that since *Erlanger Behavioral Health* is a new hospital, there is no historical financial information to report. However, copies of the following financial statements for *Erlanger Health System* are attached to this CON application.

Interim Balance Sheet & Income Statement	Dec. 30, 2015
Audited Financial Statements	June 30, 2015

11. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to,

A. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If developments of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

Response

A number of alternatives were considered and deemed not to be feasible. These alternatives included locating the proposed project at *Erlanger North Hospital* where a twelve (12) bed Geriatric-Psychiatric unit is already located, however, this was not feasible due to the topography of the site and the inability to accommodate the proposed plan in a functionally efficient manner. Also, cost was anticipated to be higher given the need for extensive site improvements. We next evaluated the *Erlanger Medical Center* campus, however, available land on the main campus is expected to be utilized for construction of a new/replacement children's hospital and for a children's ambulatory care building, leaving little to no space for the new behavioral health hospital.

Consideration was given to use of the Hamilton County Health Department site adjacent to *Erlanger Medical Center*, however, this building and services would need to be relocated and replaced, increasing project cost. Further, other land contiguous to the main campus is expected to be utilized by the city for extension of Central Avenue, connecting with Amnicola Highway. While this location is expected to reduce travel time to *Erlanger's* trauma center, insufficient space would remain for this project. Sites owned by the city and county were also evaluated, and we met and discussed the proposed project with the Chamber of Commerce and elected officials; however, these sites are contemplated to be used for higher density industrial development.

We also considered not developing the proposed project but rejected this alternative given the identified need and number of patients currently served. In the end, selection of a site located two minutes' drive from the main campus was considered the best option. The site is flat and sufficient to accommodate the proposed project.

As *the* safety net hospital in Southeast Tennessee, it is vital that *Erlanger Health System* enhance its facilities to provide the best and most accessible treatment services available for the communities we serve. As an academic medical center affiliated with the University of Tennessee College of Medicine, which is co-located on the *Erlanger Medical Center* campus, *EHS* also seeks to provide appropriate facilities so as to enhance

the training and education of medical residents and fellows as well as other health professionals. Erlanger Health System is planning for tomorrow with regard to behavioral health services for the regional service area, ensuring that the needs of the uninsured and/or low income population are being met.

B. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

Response

A number of alternatives were considered and deemed not to be feasible. These alternatives included locating the proposed project at *Erlanger North Hospital* where a twelve (12) bed Geriatric-Psychiatric unit is already located, however, this was not feasible due to the topography of the site and the inability to accommodate the proposed plan in a functionally efficient manner. Also, cost was anticipated to be higher given the need for extensive site improvements. We next evaluated the *Erlanger Medical Center* campus, however, available land on the main campus is expected to be utilized for construction of a new/replacement children's hospital and for a children's ambulatory care building, leaving little to no space for the new behavioral health hospital.

Consideration was given to use of the Hamilton County Health Department site adjacent to *Erlanger Medical Center*, however, this building and services would need to be relocated and replaced, increasing project cost. Further, other land contiguous to the main campus is expected to be utilized by the city for extension of Central Avenue, connecting with Amnicola Highway. While this location is expected to reduce travel time to *Erlanger's* trauma center, insufficient space would remain for this project. Sites owned by the city and county were also evaluated, and we met and discussed the proposed project with the Chamber of Commerce and elected officials; however, these sites are contemplated to be used for higher density industrial development.

We also considered not developing the proposed project but rejected this alternative given the identified need and number of patients currently served. In the end, selection of a site located two minutes' drive from the main campus was considered the best option. The site is flat and sufficient to accommodate the proposed project.

As *the* safety net hospital in Southeast Tennessee, it is vital that *Erlanger Health System* enhance its facilities to provide the best and most accessible treatment services available for the communities we serve. As an academic medical center affiliated with the University of Tennessee College of Medicine, which is co-located on the *Erlanger Medical Center* campus, *EHS* also seeks to provide appropriate facilities so as to enhance the training and education of medical residents and fellows as well as other health professionals. Erlanger Health System is planning for tomorrow with regard to behavioral health services for the regional service area, ensuring that the needs of the uninsured and/or low income population are being met.

(III.) *CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE*

1. List all health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.

Response

The most significant relationship between this proposal and the existing healthcare system is that it will be part of an existing health system and enhance *Erlanger Health System's* ability to integrate its services within the regional service area as the safety net provider, trauma center and region's only academic medical center.

By providing these services regardless of a patient's ability to pay, the regional healthcare delivery system is

positively impacted by the services envisioned in the instant application.

The applicant will have transfer arrangements with the following hospitals which are owned by *Erlanger Health System*.

-- Erlanger Medical Center
-- Erlanger North Hospital
-- T. C. Thompson Children's Hospital
-- Erlanger Bledsoe Hospital

Further, Erlanger currently has patient transfer agreements in place with more than 90 hospitals and other providers in the four (4) state area. These providers refer patients to *Erlanger* because of the depth and breadth of its programs and services. It is anticipated that *Erlanger Behavioral Health* will have transfer arrangements for behavioral health services with a majority of these providers. A copy of the list of transfer agreements is attached to this CON application.

2. Describe the positive and / or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

Response

The effects of this proposal will be positive for the healthcare system because it will deliver the most appropriate level of care for those who are in need of service regardless of ability to pay, and will also distribute needed services across the service area to foster improved patient access. By providing this behavioral health service, the regional healthcare delivery system is positively impacted by serving as the "safety net" for those who are otherwise in need of these necessary services.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for

the project. This can be reported using FTE's for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the *Tennessee Dept. Of Labor & Workforce Development* and/or other documented sources.

Response

Clinical staffing for *Erlanger Behavioral Health* is anticipated to be as follows:

Erlanger Bevioral Health -- FTE's By Position Type	
	== FTE's ==
	Year 2
CEO	1.0
CFO	1.0
COO	1.0
Admin Assistant	3.2
Billing	2.4
Accounting	1.4
Marketing	1.2
MD	1.6
DON	1.0
Nurse	11.3
Nurse Assistant	31.9
Social Worker	12.0
Other	31.9
Total >>>>	100.9

Appropriate salary comparison data is below.

Position	EHS Avg.	Market Mid-Point
Admin. Assistant	$ 18.03	$ 17.84
Pt. Billing	$ 16.38	$ 16.01
Accounting	$ 29.98	$ 31.93
Marketing Mgr.	$ 53.88	$ 46.21
Psychiatrist	$ 103.45	$ 102.00
Psychiatric RN	-	$ 32.75
Psych. Nurse Asst	-	$ 14.10
Social Worker	$ 27.60	$ 23.09

NOTES

(1) This information is derived from the internal records of *Erlanger Health System*. EHS does not have data for Psychiatric RN and Nurse Assistant.

(2) The market mid-point is derived from the 2015 Mercer Group Salary Survey.

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Dept. Of Health, the Dept. Of Mental Health & Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

Response

The human resources required will be approached with a proactive recruitment action plan. Historically, *Erlanger* has met staffing requirements by utilizing a variety of methods. Thus, our approach to fulfill the staffing plan for the *Erlanger Behavioral Health* will consist of a proactive plan of marketing, screening, hiring, and training.

The Human Resources Department at *Erlanger* will work closely with managers in the transition. The specifics will be based on the needs of the organization and aligned with the strategic needs of the new behavioral health servie. *Erlanger* has actively been involved in the *WorkForce* Development movement on several different levels within the Chattanooga area and statewide. Current vacancy rates are below state and national averages.

Erlanger Health System participates with numerous schools that provide advanced training in the areas of nursing and allied health. Therefore, *Erlanger* expects no difficulty in recruitment of required staff given it's role as an academic medical center and it's affiliations with colleges and universities offering allied health and related training programs.

5. Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission

privileges, quality assurance policies and programs, utilization review *policies and programs, record keeping, and staff education*.

Response

The Applicant has reviewed and intends to comply with all licensing and certification requirements imposed by applicable statutes and regulations.

6. Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).

Response

Erlanger Health System, as the region's only academic medical center, has established strong long term relationships with the region's colleges, universities and clinical programs. *Erlanger* provides clinical sites for internships and rotation programs in nursing, radiology, respiratory, pharmacy and surgery technology, to name a few. It is also expected that *Erlanger Behavioral Health* will do so as well.

A number of regional universities offer Bachelor degree programs in nursing and physical therapy. *Erlanger* works closely with the University of Tennessee at Chattanooga to assist nurses transitioning from RN to BSN. Erlanger provides a teaching environment for staff as well with various on-the-job training opportunities (ex: CT for Radiologic Technologist, Certification for LPNs). Locally, two year degrees are available in many clinical allied health areas with additional programs offering advanced technical training in Radiological Imaging such as Nuclear Medicine, Diagnostic Ultrasonography, etc. *Erlanger Health System* participates with numerous schools that provide advanced training in the areas of nursing and allied health.

Erlanger has established strong long term relationships with the region's colleges, universities and clinical programs. *Erlanger* provides clinical sites for internships and rotation programs in nursing, radiology, respiratory care and pharmacy, to name a few. A number of

regional universities offer Bachelor degree programs in nursing and physical therapy. Locally, two year degrees are available in many clinical allied health areas with additional programs offering advanced technical training in Radiological Imaging such as Nuclear Medicine and Diagnostic Ultrasonography.

The *University of Tennessee - College of Medicine* is co-located at *Erlanger* and includes training of senior medical students on clinical rotation as well as graduate medical education for training of residents and advanced fellowships in various medical specialties, including surgical specialties, as outlined below.

Residency Programs

- Emergency Medicine
- Family Medicine
- Internal Medicine
- Obstetrics & Gynecology
- Orthopedic Surgery
- Pediatrics
- Plastic Surgery
- Surgery
- Urology
- Transitional Year

Fellowship Programs

- Orthopedic Trauma Surgery
- Surgical Critical Care
- Vascular Surgery
- Colon & Rectal Surgery
- Emergency Medicine
- Neuro-Interventional Surgery
- Ultrasound
- Cardiovascular Disease
- Gastroenterology (under development)
- Radiology (under development)
- Neurology (under development)

It should be noted that *Erlanger Health System* is currently in discussions with it's academic partner, the University of Tennessee - College of Medicine, to explore the possibility of a graduate medical education and training residency program in Psychiatry.

Erlanger Health System also participates with numerous schools that provide advanced training in the areas of nursing and allied health.

7. (a) **Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Dept. Of Health, the Dept. Of Mental Health & Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.**

Response

The Applicant has reviewed and intends to comply with all licensing and certification requirements imposed by applicable statutes and regulations.

(b) **Provide the name of the entity from which the applicant has received or will receive licensure, certification, and / or accreditation.**

Licensure: State of Tennessee, Dept. of Mental Health & Substance Abuse

Accreditation: Joint Commission on Accreditation of Healthcare Organizations

If an existing institution, please describe the Current standing with any licensing, certifying, or accrediting agency or commission. Provide a copy of the current license of the facility.

Response

Erlanger Behavioral Health will continuously strive to comply with applicable regulations and make needed changes where deficiencies may arise to ensure full compliance with applicable standards of care and licensure requirements.

(c) **For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an**

approved plan of correction.

Response

*** Not Applicable. ****

8. **Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5 % ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.**

Response

This criterion is not applicable because *Erlanger Health System* operates as the Chattanooga-Hamilton County Hospital Authority, which is a governmental unit and a statutory entity under the State of Tennessee. As such, it is not possible for there to be any "owners", per se, except for the people of Hamilton County, Tennessee, and the State of Tennessee.

9. **Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5 % ownership interest in the project.**

Response

This criterion is not applicable because *Erlanger Health System* operates as the Chattanooga-Hamilton County Hospital Authority, which is a governmental unit and a statutory entity under the State of Tennessee. As such, it is not possible for there to be any "owners", per se, except for the people of Hamilton County, Tennessee, and the State of Tennessee.

10. **If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services And Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed,**

and other data as required.

Response

Applicant will provide the *Health Services And Development Agency* with appropriate information in consideration of this CON application.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of publication of the letter of intent.

Attached is a copy of the *Letter Of Intent* which was filed with the *Tennessee Health Services & Development Agency* on March 10, 2016. The original publication affidavit is also attached to this CON application.

DEVELOPMENT SCHEDULE

Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for cause shown. Subsequent to granting a Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**

   Response

   The *Project Completion Forecast Chart* has been completed and appears on the following page.

2. **If the response to the preceding question indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph, please state below any request for an extended schedule and document the "good cause" for such an extension.**

   Response

   *** Not Applicable. ***

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision Date, as published in Rule 68-11-1609(c): June 22, 2016

Assuming the CON approval becomes the final Agency action on that date; indicate the number of days from the above agency decision date to each phase of the completion forecast.

PHASE		Days Required	Anticipated Date (MONTH / YEAR)
1.	Architectural and engineering contract signed.	1	08/2016
2.	Construction documents approved by the *Tennessee Dept. Of Health.*	210	03/2017
3.	Construction contract signed.	1	03/2017
4.	Building permit secured.	15	04/2017
5.	Site preparation completed.	60	06/2017
6.	Building construction commenced.	1	06/2017
7.	Construction 40 % complete.	120	10/2017
8.	Construction 80 % complete.	120	02/2018
9.	Construction 100 % complete (approved for occupancy.	60	04/2018
10.	*Issuance of license.	30	05/2018
11.	*Initiation of service.	1	06/2018
12.	Final Architectural Certification Of Payment.	1	06/2018
13.	Final Project Report Form (HF0055).	1	06/2018

(*) For projects that do NOT involve construction or renovation, please complete items 10 and 11 only.

NOTE – If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

MAR 15 '16 AM 10:25

A F F I D A V I T

STATE OF TENNESSEE

COUNTY OF HAMILTON

Joseph M. Winick, being first duly sworn, says that he / she is the applicant named in this application or his / her / it's lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Agency Rules, and T.C.A. § 68-11-1601, *et seq*, and that the responses to this application or any other questions deemed appropriate by the Tennessee Health Services & Development Agency are true and complete.

SIGNATURE

SWORN to and subscribed before me this 11 of March (Month), 2016 (Year), a Notary Public in and for the State of Tennessee, County of Hamilton.

NOTARY PUBLIC

ROBIN S. DEBOLT
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

My commission expires October 10, 2016 (Month / Day), 20____.

TABLE OF ATTACHMENTS

Proof Of Publication

HSDA - Letter Of Intent
HSDA - Publication Of Intent
Affidavit Of Publication

Description	Section / Item
Secretary Of State Acknowledgement	A-4
Articles Of Organization	A-4
Letter Of Agreement - Real Estate Option	A-6
Option To Purchase Real Estate	A-6
Square Footage & Cost Per Square Foot Chart	B-II-A
Erlanger Behavioral Health - Site Plan	B-III-A
Erlanger Behavioral Health - Floor Plans	B-IV
Service Area	C-I-3
Architect Letter - Construction Cost	C-II-1
Funding - Acadia CFO Letter	C-II-2
Other Expenses - Historical Data Chart	C-II-4
Other Expenses - Projected Data Chart	C-II-4
Erlanger Interim Financial Statements	C-II-10
Erlanger Audited Financial Statements	C-II-10
List Of Erlanger Patient Transfer Agreements	C-III-1

ATTACHMENTS

Proof Of Publication

HSDA - Letter Of Intent
HSDA - Publication Of Intent
Affidavit Of Publication

LETTER OF INTENT
TENNESSEE HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Chattanooga Times Free Press, which is a newspaper of general circulation in Hamilton County, Tennessee, on or before March 10, 2016, for one day.

This is to provide official notice to the Health Services & Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et. seq.*, and the Rules of the Health Services & Development Agency, that Erlanger Behavioral Health, LLC, with an ownership type of for profit, and to be managed by itself, intends to file an application for a Certificate of Need ("CON") to construct a new psychiatric hospital with a total complement of eighty-eight (88) inpatient beds, to include services for inpatients, outpatients and substance abuse. Further, we are requesting approval to transfer twelve (12) licensed Geriatric – Psychiatric beds currently at Erlanger North Hospital to the new Erlanger Behavioral Health campus. This will create a net addition of seventy-six (76) new inpatient psychiatric beds. If approved, the number of hospital beds at Erlanger North Hospital will decrease from fifty seven (57) beds to forty-five (45) beds upon completion of the project. No other health care services will be initiated or discontinued.

The facility and equipment will be located at Erlanger Behavioral Health, at a site located at the intersection of North Holtzclaw Avenue & Citico Avenue, Chattanooga, Hamilton County, Tennessee, 37404. The total project cost is estimated to be $ 25,112,600.00.

The anticipated date of filing the application is March 15, 2016.

The contact person for this project is Joseph M. Winick, Sr. Vice President, Erlanger Health System, 975 East 3rd Street, Chattanooga, Tennessee, 37403, and by phone at (423) 778-7274.

Joseph M. Winick	March 8, 2016	Joseph.Winick@erlanger.org
	Date:	E-Mail:

The Letter Of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter Of Intent must contain the following statement pursuant to T.C.A. §68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Chattanooga Times Free Press
TIMESFREEPRESS.COM
VOL. 147 › NO. 87 › $1.00
THURSDAY
MARCH 10, 2016

LEGAL NOTICES

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services & Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et. seq., and the Rules of the Health Services & Development Agency, that Erlanger Behavioral Health, LLC, with an ownership type of for profit, and to be managed by itself, intends to file an application for a Certificate of Need ("CON") to construct a new psychiatric hospital with a total complement of eighty-eight (88) inpatient beds, to include services for inpatients, outpatients and substance abuse. Further, we are requesting approval to transfer twelve (12) licensed Geriatric - Psychiatric beds currently at Erlanger North Hospital to the new Erlanger Behavioral Health campus. This will create a net addition of seventy-six (76) new inpatient psychiatric beds. If approved, the number of hospital beds at Erlanger North Hospital will decrease from fifty seven (57) beds to forty-five (45) beds upon completion of the project. No other health care services will be initiated or discontinued.

The facility and equipment will be located at Erlanger Behavioral Health, at a site located at the intersection of North Holtzclaw Avenue & Citico Avenue, Chattanooga, Hamilton County, Tennessee, 37404. The total project cost is estimated to be $ 25,112,600.00.

The anticipated date of filing the application is March 15, 2016.

The contact person for this project is Joseph M. Winick, Sr. Vice President, Erlanger Health System, 975 East 3rd Street, Chattanooga, Tennessee, 37403, and by phone at (423) 778-7274.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

Pursuant to T.C.A. § 68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate Of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

2788719
ERLANGER STRATEGIC

STATE OF TENNESSEE
HAMILTON COUNTY

Before me personally appeared Jim Stevens who being duly sworn, that he is the Legal Sales Representative of the "CHATTANOOGA TIMES FREE PRESS" and that the Legal Ad of which the attached is a true copy, has been published in the above said Newspaper and on the website on the following dates, to-wit:

March 10, 2016

And that there is due or has been paid the "CHATTANOOGA TIMES FREE PRESS" for publication of such notice the sum of $223.71 Dollars. (Includes $10.00 Affidavit Charge).

Jim Stevens

Sworn to and subscribed before me, this 10th day of March, 2016.

Amanda Crawford

AMANDA CRAWFORD
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY
MY COMMISSION EXPIRES OCTOBER 17, 2018

My Commission Expires 10/17/2018

Chattanooga Times Free Press

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services & Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et. seq., and the Rules of the Health Services & Development Agency, that Erlanger Behavioral Health, LLC, with an ownership type of for profit, and to be managed by itself, intends to file an application for a Certificate of Need ("CON") to construct a new psychiatric hospital with a total complement of eighty-eight (88) inpatient beds, to include services for inpatients, outpatients and substance abuse. Further, we are requesting approval to transfer twelve (12) licensed Geriatric - Psychiatric beds currently at Erlanger North Hospital to the new Erlanger Behavioral Health campus. This will create a net addition of seventy-six (76) new inpatient psychiatric beds. If approved, the number of hospital beds at Erlanger North Hospital will decrease from fifty seven (57) beds to forty-five (45) beds upon completion of the project. No other health care services will be initiated or discontinued.

The facility and equipment will be located at Erlanger Behavioral Health, at a site located at the intersection of North Holtzclaw Avenue & Citico Avenue, Chattanooga, Hamilton County, Tennessee, 37404. The total project cost is estimated to be $ 25,112,600.00.

The anticipated date of filing the application is March 15, 2016.

The contact person for this project is Joseph M. Winick, Sr. Vice President, Erlanger Health System, 975 East 3rd Street, Chattanooga, Tennessee, 37403, and by phone at (423) 778-7274.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

Pursuant to T.C.A. § 68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate Of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Description	Section / Item
Secretary Of State Acknowledgement	A-4
Articles Of Organization	A-4

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

Erlanger Behavioral Health, LLC
975 E 3RD ST
CHATTANOOGA, TN 37403-2147

March 7, 2016

Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepancies.

SOS Control # :	**000838066**	Formation Locale:	TENNESSEE
Filing Type:	Limited Liability Company - Domestic	Date Formed:	03/07/2016
Filing Date:	03/07/2016 3:15 PM	Fiscal Year Close:	6
Status:	Active	Annual Report Due:	10/01/2016
Duration Term:	Perpetual	Image # :	B0210-0685
Managed By:	Director Managed		
Business County:	HAMILTON COUNTY		

Document Receipt

Receipt # : 002510157	Filing Fee:	$300.00
Payment-Check/MO - BAKER, DONELSON, BEARMAN, CALDWELL & BERKOWITZ, NASHVILI		$300.00

Registered Agent Address:
NATIONAL REGISTERED AGENTS, INC.
STE 2021
800 S GAY ST
KNOXVILLE, TN 37929-9710

Principal Address:
975 E 3RD ST
CHATTANOOGA, TN 37403-2147

Congratulations on the successful filing of your **Articles of Organization** for **Erlanger Behavioral Health, LLC** in the State of Tennessee which is effective on the date shown above. You must also file this document in the office of the Register of Deeds in the county where the entity has its principal office if such principal office is in Tennessee. Please visit the Tennessee Department of Revenue website (apps.tn.gov/bizreg) to determine your online tax registration requirements. If you need to obtain a Certificate of Existence for this entity, you can request, pay for, and recieve it from our website.

You must file an Annual Report with this office on or before the Annual Report Due Date noted above and maintain a Registered Office and Registered Agent. Failure to do so will subject the business to Administrative Dissolution/Revocation.

Tre Hargett
Secretary of State

Processed By: Carol Dickerson

ARTICLES OF ORGANIZATION
LIMITED LIABILITY COMPANY (ss-4270)

Business Services Division
Tre Hargett, Secretary of State
State of Tennessee
312 Rosa L. Parks AVE, 6th Fl.
Nashville, TN 37243-1102
(615) 741-2286

Filing Fee: $50.00 per member
(minimum fee = $300, maximum fee = $3,000)

For Office Use Only

FILED

The Articles of Organization presented herein are adopted in accordance with the provisions of the Tennessee Revised Limited Liability Company Act.

1. The name of the Limited Liability Company is: Erlanger Behavioral Health, LLC

(NOTE: Pursuant to the provisions of T.C.A. §48-249-106, each Limited Liability Company name must contain the words "Limited Liability Company" or the abbreviation "LLC" or "L.L.C.")

2. Name Consent: (Written Consent for Use of Indistinguishable Name)
☐ This entity name already exists in Tennessee and has received name consent from the existing entity.

3. This company has the additional designation of: N/A

4. The name and complete address of the Limited Liability Company's initial registered agent and office located in the state of Tennessee is:
Name: National Registered Agents, Inc.
Address: 800 S. Gay Street, Suite 2021
City: Knoxville State: TN Zip Code: 37929 County: Knox

5. Fiscal Year Close Month: June

6. If the document is not to be effective upon filing by the Secretary of State, the delayed effective date and time is: (Not to exceed 90 days)
Effective Date: ____/____/____ (Month/Day/Year) Time: _____

7. The Limited Liability Company will be: ☐ Member Managed ☐ Manager Managed ☒ Director Managed

8. Number of Members at the date of filing: 1

9. Period of Duration: ☒ Perpetual ☐ Other ____/____/____ (Month/Day/Year)

10. The complete address of the Limited Liability Company's principal executive office is:
Address: 975 East 3rd Street
City: Chattanooga State: TN Zip Code: 37419 County: Hamilton

ARTICLES OF ORGANIZATION
LIMITED LIABILITY COMPANY (ss-4270)

For Office Use Only

Business Services Division
Tre Hargett, Secretary of State
State of Tennessee
312 Rosa L. Parks AVE, 6th Fl.
Nashville, TN 37243-1102
(615) 741-2286

Filing Fee: $50.00 per member
(minimum fee = $300, maximum fee = $3,000)

The name of the Limited Liability Company is: Erlanger Behavioral Health, LLC

11. The complete mailing address of the entity (If different from the principal office) is:

Address: Same as above

City: _____ State: _____ Zip Code: _____

12. Non-Profit LLC (required only if the Additional Designation of "Non-Profit LLC" is entered in section 3.)

☐ I certify that this entity is a Non-Profit LLC whose sole member is a nonprofit corporation, foreign or domestic, incorporated under or subject to the provisions of the Tennessee Nonprofit Corporation Act and who is exempt from franchise and excise tax as not-for-profit as defined in T.C.A. §67-4-2004. The business is disregarded as an entity for federal income tax purposes.

13. Professional LLC (required only if the Additional Designation of "Professional LLC" is entered in section 3.)

☐ I certify that this PLLC has one or more qualified persons as members and no disqualified persons as members or holders.

Licensed Profession: _____

14. Series LLC (required only if the Additional Designation of "Series LLC" is entered in section 3.)

☐ I certify that this entity meets the requirements of T.C.A. §48-249-309(a) & (b)

15. Obligated Member Entity (list of obligated members and signatures must be attached)

☐ This entity will be registered as an Obligated Member Entity (OME) Effective Date: ____/____/____ (Month / Day / Year)

☐ I understand that by statute: THE EXECUTION AND FILING OF THIS DOCUMENT WILL CAUSE THE MEMBER(S) TO BE PERSONALLY LIABLE FOR THE DEBTS, OBLIGATIONS AND LIABILITIES OF THE LIMITED LIABILITY COMPANY TO THE SAME EXTENT AS A GENERAL PARTNER OF A GENERAL PARTNERSHIP. CONSULT AN ATTORNEY.

16. This entity is prohibited from doing business in Tennessee:

☐ This entity, while being formed under Tennessee law, is prohibited from engaging in business in Tennessee.

17. Other Provisions: The following are appointed as the initial directors of the Limited Liability Company:

Gregg Gentry, Joseph Winick, FACHE, Robert Brooks, FACHE, Jeff Woodard, and Britt Tabor, FACHE.

March 4, 2016
Signature Date

Philip S McSween
Signature

Organizer
Signer's Capacity (If other than individual capacity)

Philip S. McSween
Name (printed or typed)

Rev. 10/12

RDA 2458

Description	Section / Item
Letter Of Agreement - Real Estate Option	A-6
Option To Purchase Real Estate	A-6

erlanger

February 17, 2016

Mr. Jimmy Hudson, President
Hudson Companies @ The Terrace at Frazier
Suite 201
345 Frazier Avenue
Chattanooga, TN

RE: Option Agreement
Erlanger Real Estate

Dear Mr. Hudson:

Attached is an edited and updated version of the option agreement to be utilized to secure the property we have discussed. Please review and let me know if questions.

In connection with the attached option agreement, this letter of agreement ("LOA") serves to memorialize the following agreement and understandings between Erlanger Health System ("Erlanger") and Hickory Land Company, LLC ("Purchaser") regarding that certain Option to Purchase Real Estate ("Option Agreement") between Medical Development Partners, LLC ("Seller") and Purchaser. Purchaser acknowledges that the Option Agreement provides for the right of Purchaser to assign the Option Agreement and the rights under such at any time with Seller's consent.

Purchaser further agrees that it is entering into such Option Agreement on Erlanger's behalf and agrees, upon notice from Erlanger, to execute an Assignment and Assumption Agreement whereby Purchaser irrevocably assigns to Erlanger or to a subsidiary or affiliate of Erlanger (including a joint venture) at Erlanger's discretion, all of Purchaser's rights, benefits, title, interests, liabilities and obligations as Purchaser under the Option Agreement and any other necessary ancillary documents related to the Option Agreement or purchase of the subject real estate.

Purchaser further agrees to not exercise any of Purchaser's rights under the Option Agreement without Erlanger's consent. In the event the Option Agreement has not been assigned prior to the expiration of the initial 6 months, Purchaser agrees to only renew its option to purchase under the Option Agreement upon the consent of Erlanger. In the event of such, Purchaser shall pay Seller the full sum of the Earnest Money and Erlanger, or its subsidiary or affiliate, as appropriate, shall reimburse Purchaser such amount.

Purchaser agrees not to make any public announcements regarding this relationship and transaction or to disclose any information related thereto, including this LOA, without the prior written consent of Erlanger.

Erlanger shall pay Purchaser the commission specified in the Listing Agreement submitted by Purchaser to Erlanger on the terms set forth therein. Erlanger shall indemnify, defend and hold harmless Purchaser for any claims, losses and expenses whatsoever, incurred by Purchaser, acting within the scope of his agency relationship.

Sincerely,

Joseph M. Winick, FACHE
Senior Vice President,
Planning, Analytics & Business Development

Agreed (Purchaser)
Hickory Land Company, LLC

By: _____
Jimmy Hudson, President

Cc: Mike Baker

OPTION TO PURCHASE REAL ESTATE

THIS AGREEMENT, made and entered into this 8th day of March, 2016, by and between **Medical Development Partners, LLC**, a TN Corp. ("Seller") a **Hickory Land Company, LLC**, TN Corp ("Purchaser").

WITNESSETH:

WHEREAS, Seller is the owner of certain real property, located in the City of Chattanooga, County of Hamilton, State of Tennessee, being a tract of land containing 6 acres, more or less, located at 804 N. Holtzclaw Ave, and more particularly described as Tax Parcel(s) 146C A 022 & 023 and hereafter referred to as "the Property"; and

WHEREAS, Purchaser desires to secure an option to purchase the Property from Seller, and Seller desires to grant such option to Purchaser;

NOW, THEREFORE, in consideration of the foregoing, and the mutual covenants and promises herein contained, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto hereby covenant and agree as follows:

1. Option to Purchase.

(a) In consideration of the sum of Ten Dollars ($10.00) paid to Seller by Purchaser, the receipt and sufficiency of which is hereby acknowledged, Seller hereby grants to Purchaser the exclusive right and option to purchase the Property, together with all improvements, easements, and appurtenances thereto.

(b) This option to purchase shall remain in effect for a period of Nine Months, (270 days) from the date of this agreement, and shall expire on the 8th day of December 2016, at 12:00 o'clock noon, Eastern Time (the "Expiration Date"), after which time this option to purchase shall be null and void and of no further legal force and effect unless Purchaser has exercised its option pursuant to the provisions of paragraph 2 hereof or renewed its option pursuant to the provisions of paragraph 1(c) hereof.

(c) Purchaser may renew this option for an additional period of Three Months, (90 days) from the Expiration Date by paying to Seller additional consideration of **Fifty Thousand Dollars ($50,000)** before the Expiration Date. The terms and conditions of this Agreement shall apply to any such renewal.

2. Notice of Exercise and Payment of Earnest Money.

At any point during the initial nine month option period or renewal option. Purchaser may give Seller written notice of its intention to exercise this option to purchase, which notice shall be delivered in person or by registered or certified mail as hereinafter prescribed, within the option period, together with payment of the sum of **Fifty Thousand Dollars ($50,000)** by certified check or cashier's check (the "Earnest Money"). Upon such notice and payment of the Earnest Money, this agreement shall automatically become a contract of purchase and sale, binding upon Seller and Purchaser as hereinafter set forth.

3. Purchase Price and Payment.

The total purchase price for the Property shall be **Eight Hundred Twenty Five Thousand Dollars** ($825,000). All payments made by Purchaser as consideration for this option or any renewal hereof and the Earnest Money shall be credited toward the total purchase price. The remainder of the total purchase price shall be paid by certified check or cashier's check on the date of closing (as herein defined).

4. Closing and Conditions Precedent to Closing.

(a) Upon receipt by Seller of Purchaser's notice of intent to exercise the option granted hereunder, the closing of this transaction shall take place on or before the 60th day following such receipt at such time and place as agreed to by Seller and Purchaser, unless Seller and Purchaser agree to postpone the closing to a later date.

(b) During the initial 9 month option period and the renewal option, if applicable. Purchaser shall retain all rights to complete inspections, including but not limited to land surveys, environmental studies, utilities and progress in pending zoning changes with written notice to Seller, and at any point prior to exercising its option to purchase under Section 2. Purchaser may terminate this agreement for reason of an unsatisfactory inspection or determination that the property is not sufficient to meet Purchaser's intended use. Upon such termination all Earnest Money paid will be returned to Purchaser immediately.

(c) Seller is the sole owner of, and has good and markable leasehold title to, the Property, and the Property is free and clear of all liens, encumbrances, claims, demands, easements, covenants, restrictions and encroachments of any kind or nature. Provider however, if the Property is subject to liens and security interests in favor of _____ ("Creditor") and may not be transferred without the consent of Creditor. Upon receipt by Seller of Purchaser's notice of intent to exercise this option, Seller will use its best efforts to obtain the consent of Creditor to the sale of the Property and the release of the liens and security interests of Creditor upon terms satisfactory to Seller. If Seller is unable to obtain such consents and/or releases, this option shall terminate and be of no further force or effect and Seller shall return to Purchaser all consideration paid for this option or any renewal thereof pursuant to paragraph 1 hereof and all Earnest Money paid by Purchaser to Seller.

(d) Seller represents to the best of Seller's knowledge, unless otherwise disclosed, that the Property is not in a Special Flood Hazard Area or floodplain; there are no violations of building, zoning or fire codes; there are no encroachments or violations of setback lines, easements or property boundary lines; and there are no boundary line disputes. If at any time the title examination, mortgage loan inspection, survey or other information discloses any such defects, or if the Purchaser discovers that any representation in this agreement is fact untrue. Purchaser may, by delivering written notice to seller, either (1) accept the Property with the defects, OR (2) cancel this Agreement and all Earnest Money will be refunded to Buyer. OR (3) Purchaser may extend the closing date up to 14 calendar days to perform additional due diligence, retaining the right to exercise option (1) or (2) above.

(e) At the time of closing, Purchaser shall deliver to Seller a certified or cashier's check in the amount of the Final Balance.

(f) At the time of closing, Seller shall deliver to Purchaser a general warranty deed in proper form for recording, with the usual covenants and warranties, conveying good and marketable title (such as will be insured by any responsible title insurance company) to the Property in fee simple to Purchaser, its successors, assigns, or nominee, subject to all easements, covenants, agreements, and restrictions of record or set forth on attached Exhibit B. In the event title is not as herein set forth, Purchaser may either take such title as Seller can give without abatement of price, or demand in writing the return of all monies paid by Purchaser, which return Seller agrees to make, and in the latter event, there shall be no further obligation by either of the parties hereto, and this Agreement shall become null and void.

(g) All ad valorem real property taxes for the year in which the sale of the property takes place shall be prorated to the date of closing. Likewise, should Purchaser desire to continue in force any insurance of the Property issued to Seller, the premiums for all such insurance shall be prorated to the date of closing.

(h) Purchaser shall pay all costs associated with closing, including preparation of the general warranty deed, closing fees, recording fees and transfer taxes in connection with the delivery and recordation of the general warranty deed.

5. Title Insurance.

Owner's title insurance in connection with the purchase of the Property contemplated herein shall be the responsibility of Seller. Seller agrees that it will cooperate with Purchaser in its efforts to obtain owner's title insurance and will supply any documents and information in its possession concerning title to the Property which are requested by Purchaser.

6. Purchaser's Right of Inspection.

During the option period, and during that period after exercise of the option but prior to the date of closing, Purchaser, together with its agents and employees, shall have the right and is hereby authorized to enter upon the Property and make such inspections of the land, surveys, and soil tests on the Property as they shall deem necessary and appropriate, together with such other investigations with respect to the current zoning of the Property and allowed uses of the Property as they shall deem necessary and appropriate.

7. Condemnation of Property.

In the event that prior to the date of closing the Property is condemned, then Seller hereby agrees to return to Purchaser (a) all consideration paid for this option or any renewal hereof if such condemnation occurs before exercise of the option, or (b) all consideration paid for this option together with the Earnest Money paid upon exercise, if such condemnation occurs after exercise of this option but before the date of closing. Such refund payment shall be made by Seller with or without demand by Purchaser.

8. Possession.

Seller shall continue in possession of the Property during the term of this option and thereafter, if such option is exercised, until the date of closing, and Seller shall maintain the Property in its present condition.

9. Commissions and Finder's Fees.

Each of the parties represents that the negotiations relative to this Agreement and the transactions contemplated hereby have been carried on by Purchaser directly with Seller and in such manner as not to give rise to any valid claims against any of the parties hereto for a brokerage commission, finder's fee, or other like payment.

10. Default by Purchaser.

Should Purchaser, after exercise of this option, fail to carry out and perform in accordance with all the terms and provisions of this Agreement, all consideration paid for this option, including any consideration paid for renewal of this option, and the Earnest Money shall be forfeited by Purchaser as liquidated damages.

11. Notice.

Any notice required to be given under this Agreement, or which either party desires to give to the other, shall be in writing and shall be deemed given when deposited in the United States mail (registered or certified mail with return receipt requested), postage prepaid, and addressed as follows:

Seller: Medical Development Partners, LLC
201 W. East Main Street, Suite 100
Chattanooga TN 37408
(Jon@kphdevelopment.com)

Purchaser: Hickory Land Company
5959 Shallowford Road, Suite 433
Chattanooga TN 37421
jimmy@hudson-companies.com

12. Assignment.

Purchaser shall have the right to assign this Agreement at any time without prior consent of Seller.

13. Binding Effect.

This Agreement shall be binding upon and inure to the benefit of the successors and assigns of Seller and Purchaser.

14. Entire Agreement.

This Agreement constitutes the entire agreement between the parties. No representations, warranties, or promises, other than as expressly set out herein, have been made by either party to the other to induce the execution of this Agreement. No waiver or modification of this Agreement shall be effective unless in writing and duly signed by the parties hereto.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year first above written.

SELLER:

ATTEST:

By: _____
JON M. KINSEY, CHIEF MANAGER

PURCHASER:

ATTEST:

By _____
Jim Hudson, III, President

STATE OF Tennessee :

COUNTY OF Hamilton :

Before me, a Notary Public of the state and county aforesaid, personally appeared Jimmy Hudson and _____, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged themselves to be President and _____ of Hickory Land, the within named bargainor, a corporation, and that they as such President and _____, executed the foregoing instrument for the purposes therein contained, by signing the name of the corporation by themselves as President and _____.

WITNESS my hand and seal, at office in Chattanooga, TN, this 8th day of March, 2016.

MARILYN RAMEY STATE OF TENNESSEE NOTARY PUBLIC HAMILTON COUNTY

Marilyn Ramey
Notary Public
My Commission Expires: 12/8/18

STATE OF Tennessee :

COUNTY OF Hamilton :

Before me, a Notary Public of the state and county aforesaid, personally appeared Jon M. Kinsey and _____, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged themselves to be Chief Manager and _____ of Medical Development Partners, the within named bargainor, a corporation, and that they as such Chief Manager and _____, executed the foregoing instrument for the purposes therein contained, by signing the name of the corporation by themselves as Chief Manager and _____.

WITNESS my hand and seal, at office in Chattanooga, TN, this 8th day of March, 2016.

DEIRDRE K. HAMILL STATE OF TENNESSEE NOTARY PUBLIC HAMILTON COUNTY

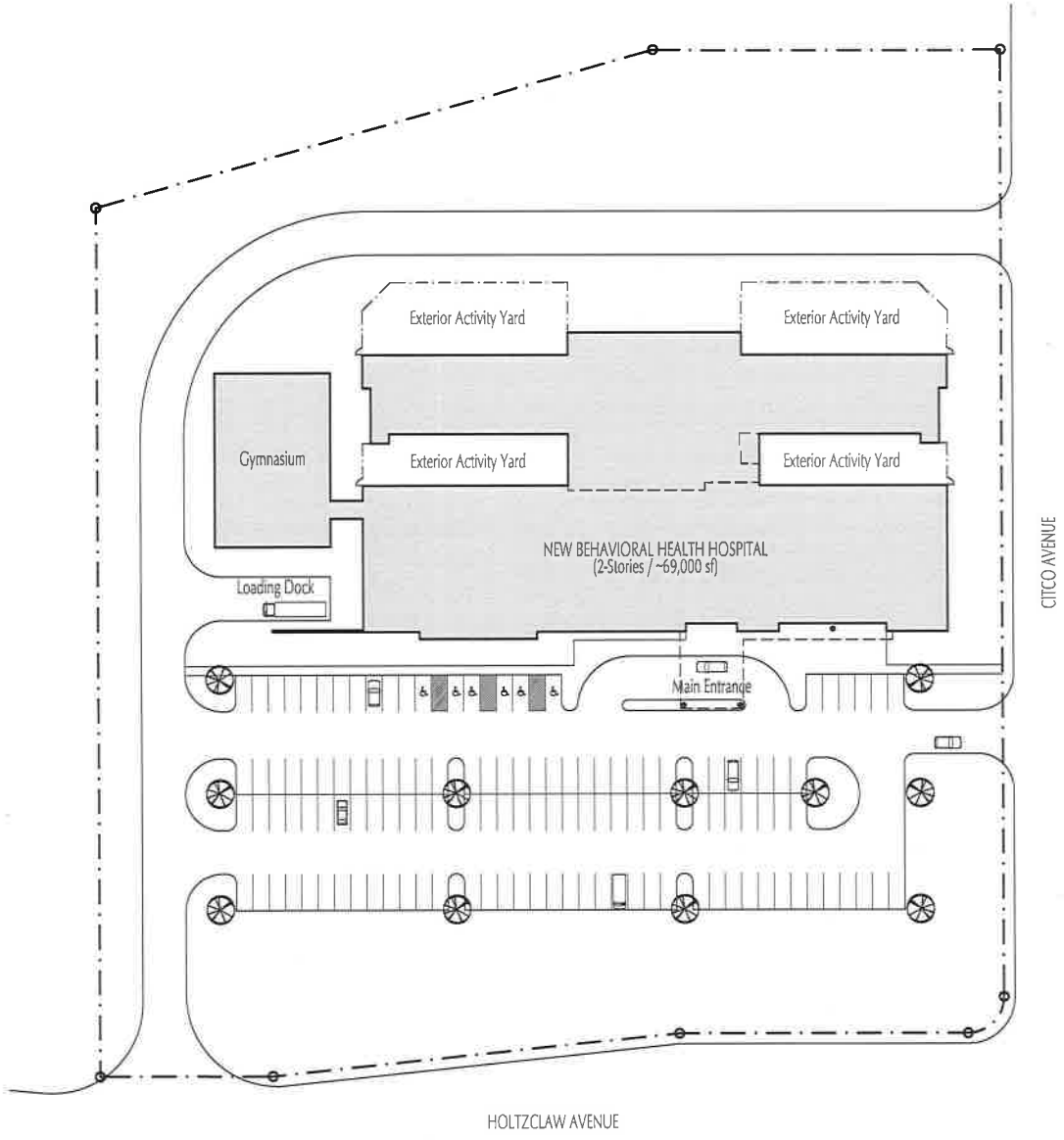
Deirdre K Hamill
Notary Public
My Commission Expires 07-10-17

Description	Section / Item
Square Footage & Cost Per Square Foot Chart	B-II-A

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost / SF		
					Renovated	New	Total	Renovated	New	Total
Administration						3,850	3,850		$ 271.30	$ 1,044,505
Building Support						1,770	1,770		$ 271.30	$ 480,201
Dietary						4,510	4,510		$ 271.30	$ 1,223,563
Education / Activity Therapy						5,360	5,360		$ 271.30	$ 1,454,168
Inpatient Nursing Units						23,580	23,580		$ 271.30	$ 6,397,254
Outpatient Therapy						2,775	2,775		$ 271.30	$ 752,858
Pharmacy						300	300		$ 271.30	$ 81,390
Public Spaces						880	880		$ 271.30	$ 238,744
B. Unit/Department GSF Sub-Total						43,025	43,025		$ 271.30	$ 11,672,683
C. Mechanical / Electrical GSF						990	990		$ 271.30	$ 268,587
D. Circulation / Structure GSF						24,985	24,985		$ 271.31	$ 6,778,730
E. Total GSF						69,000	69,000		$ 271.30	$ 18,720,000

Description	Section / Item
Erlanger Behavioral Health - Site Plan	B-III-A



AREA SUMMARY	
New Building Area - First Floor	50,900 sf
New Building Area - Second Floor	18,100 sf
TOTAL NEW BUILDING AREA	69,000 sf

NORTH

GRAPHIC SCALE

0' 50' 100' 200'

CONCEPTUAL SITE PLAN

SEE GRAPHIC SCALE

NEW BEHAVIORAL HEALTH HOSPITAL
ERLANGER BEHAVIORAL HEALTH, LLC
CHATTANOOGA, TENNESSEE

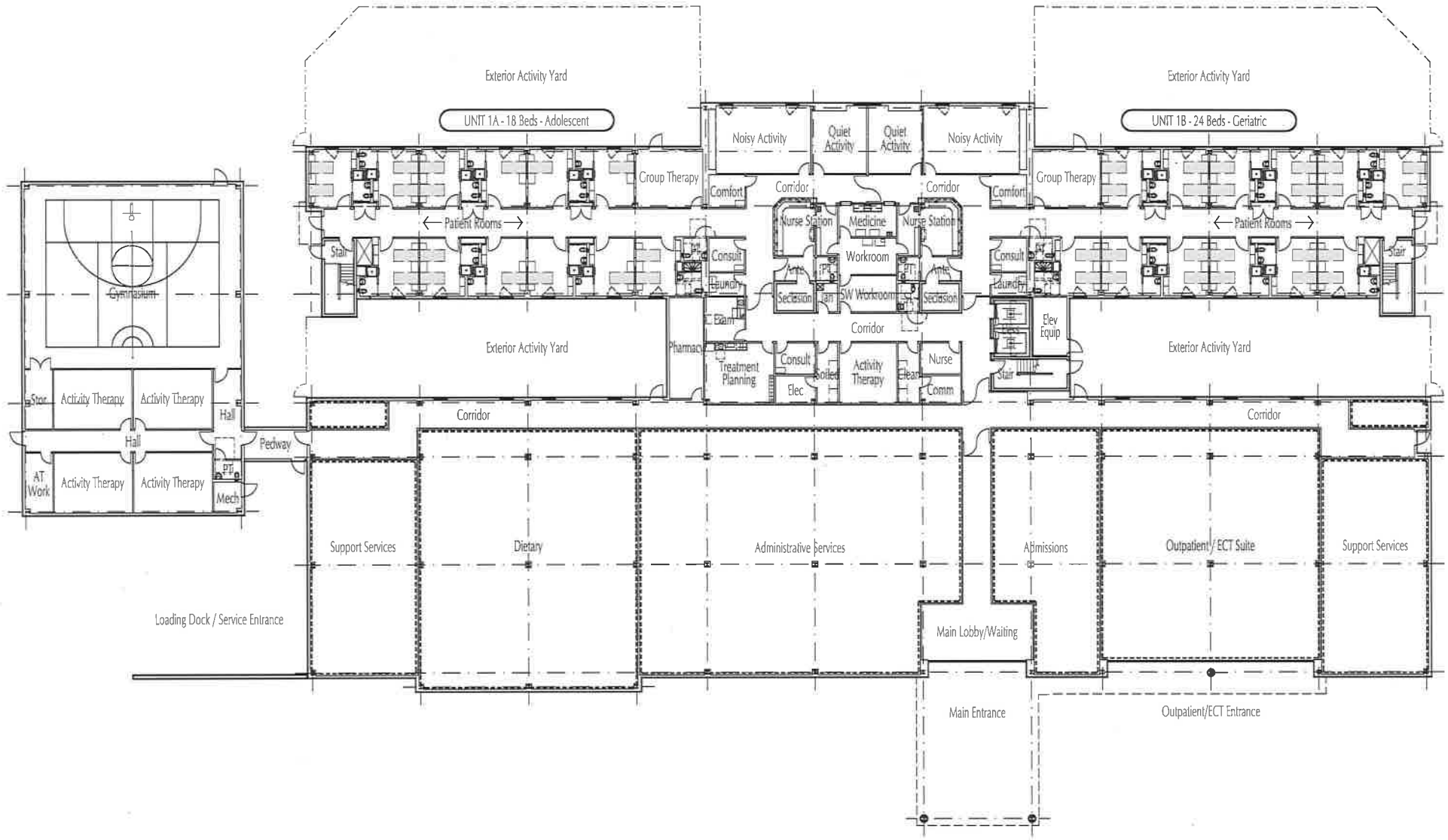
CO01-00

AHC1504

14 MARCH 2016

STENGEL-HILL ARCHITECTURE
613 WEST MAIN STREET LOUISVILLE, KENTUCKY 40202 502.893.1875 502.893.1876 fax

Description	Section / Item
Erlanger Behavioral Health - Floor Plans	B-IV



AREA SUMMARY	
New Building Area - First Floor	50,900 sf
New Building Area - Second Floor	18,100 sf
TOTAL NEW BUILDING AREA	69,000 sf

NORTH

GRAPHIC SCALE

0' 20' 40' 80'

CONCEPTUAL FIRST FLOOR PLAN

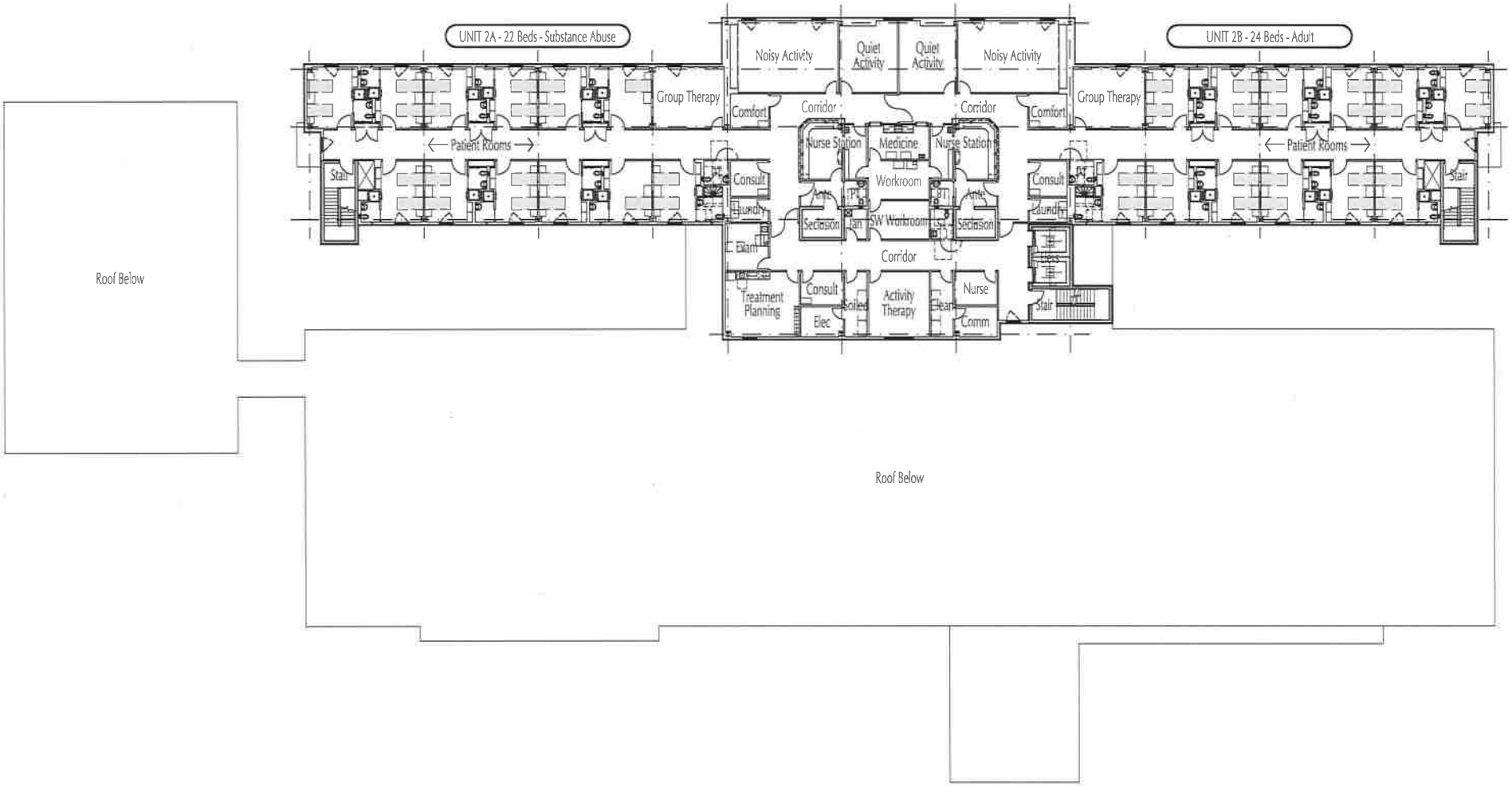
SEE GRAPHIC SCALE

NEW BEHAVIORAL HEALTH HOSPITAL
ERLANGER BEHAVIORAL HEALTH, LLC
CHATTANOOGA, TENNESSEE

C001-01

AHC1504 | 14 MARCH 2016

STENGEL-HILL ARCHITECTURE
613 WEST MAIN STREET LOUISVILLE, KENTUCKY 40202 502.893.1875 502.893.1876 fax



AREA SUMMARY	
New Building Area - First Floor	50,900 sf
New Building Area - Second Floor	18,100 sf
TOTAL NEW BUILDING AREA	69,000 sf

NORTH

GRAPHIC SCALE

0' 20' 40' 80'

CONCEPTUAL SECOND FLOOR PLAN

SEE GRAPHIC SCALE

NEW BEHAVIORAL HEALTH HOSPITAL
ERLANGER BEHAVIORAL HEALTH, LLC
CHATTANOOGA, TENNESSEE

C001-02

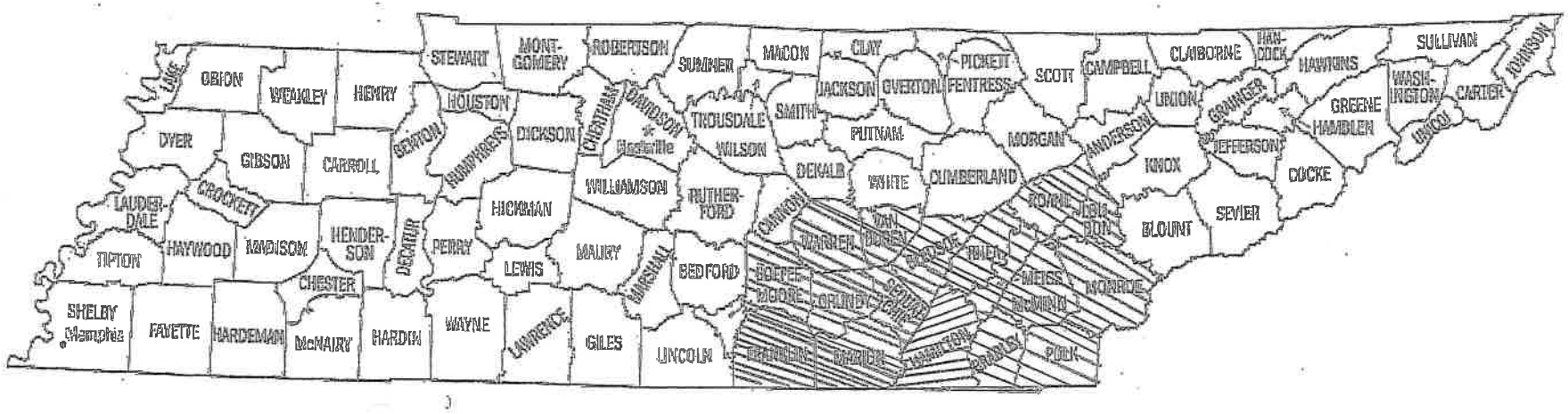
AHC1504

14 MARCH 2016

STENGEL-HILL ARCHITECTURE
613 WEST MAIN STREET LOUISVILLE, KENTUCKY 40202 502.893.1875 502.893.1876 fax

Description	Section / Item
Service Area	C-I-3

County	State	Service Area
Hamilton	TN	PSA
Bledsoe	TN	SSA
Bradley	TN	SSA
Grundy	TN	SSA
Marion	TN	SSA
McMinn	TN	SSA
Meigs	TN	SSA
Polk	TN	SSA
Rhea	TN	SSA
Sequatchie	TN	SSA
Catoosa	GA	SSA
Dade	GA	SSA
Walker	GA	SSA
Dekalb	AL	TSA
Jackson	AL	TSA
Chattooga	GA	TSA
Fannin	GA	TSA
Gilmer	GA	TSA
Gordon	GA	TSA
Murray	GA	TSA
Whitfield	GA	TSA
Cherokee	NC	TSA
Coffee	TN	TSA
Cumberland	TN	TSA
Franklin	TN	TSA
Loudon	TN	TSA
Monroe	TN	TSA
Roane	TN	TSA
Van Buren	TN	TSA
Warren	TN	TSA



Primary Service Area

Secondary & Tertiary Service Area


La Vergne
Franklin
Smyrna
Murfreesboro
Oak Ridge
Knoxville
Roane
Maryville
Warren
TENNESSEE
Loudon
Monroe
Grundy
Sequatchie
Franklin
Marion
Hamilton
Cleveland
Bradley
Polk
Cherokee
NORTH
CAROLINA
Chattanooga
East Ridge
Fannin
Jackson
Dalton
Huntsville
Madison
Decatur
Gilmer
ALABAMA
GEORGIA
De Kalb
Rome
Gainesville
Copyright © and (P) 1988-2012 Microsoft Corporation and/or its suppliers. All rights reserved.

Description	Section / Item
Architect Letter - Construction Cost	C-II-1

Joseph M. Winick, FACHE
Senior Vice President
Planning, Analytics & Business Development
Erlanger Health System
975 East 3rd Street
Chattanooga, TN 37403

RE: Attestation of Construction Cost
New Behavioral Health Hospital
Erlanger Behavioral Health, LLC
Chattanooga, Tennessee

14 March 2016

SHA.AHC1504

Joe,

Per recent conversations with you regarding a Certificate of Need Submission for a New Behavioral Health Hospital for Erlanger Behavioral Health, LLC in Chattanooga, Tennessee, I have prepared the following supporting documentation for your review.

I have reviewed the construction cost estimate provided by Erlanger Behavioral Health, LLC in the CON Submission for this Project. Based on my experience and knowledge of the current health care market, it is my opinion that the projected construction cost of $18,720,000 appears to be reasonable for a project of this type and size.

Additionally, please note that the Project will be designed in compliance with all applicable State and Federal Regulations, including the following:

- → Guidelines for the Design and Construction of Health Care Facilities
- → Rules of the Tennessee Department of Health - Board for Licensing Health Care Facilities
- → International Building Code
- → National Electrical Code
- → National Fire Protection Association (NFPA) Codes
- → Americans with Disabilities Act (ADA)

If you have any questions or comments regarding this information, please do not hesitate to contact me at your convenience.

Thank you.

Bradford P. Stengel, AIA
Senior Principal
Stengel Hill Architecture Incorporated
Tennessee Registered Architect No. #000102 523

copy: Andy Hanner AHC

613 WEST MAIN STREET LOUISVILLE, KENTUCKY 40202
tel: 502.893.1875 fax: 502.893.1876 www.stengelhill.com

Description	Section / Item
Funding - Acadia CFO Letter	C-II-2

ACADIA
HEALTHCARE

March 11, 2016

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Frost Building, Third Floor
161 Rosa Parks Boulevard
Nashville, Tennessee 37203

RE: Financing Commitment
Erlanger Behavioral Health, LLC
Hamilton County

Dear Mrs. Hill:

Erlanger Behavioral Health, LLC, a proposed joint venture of Erlanger Health System and Acadia Healthcare, is applying for a Certificate of Need to establish a new psychiatric and substance abuse hospital in Hamilton County.

This letter is to confirm that Acadia Healthcare will provide the approximately $25,112,600 in funding required to construct the hospital and implement that project. Acadia intends to finance these costs with cash on hand and borrowings from its existing revolving credit facility.

Please let me know if you have any questions.

Sincerely,

David Duckworth
CFO

Description	Section / Item
Other Expenses - Historical Data Chart	C-II-4
Other Expenses - Projected Data Chart	C-II-4

Historical Data Chart -- Summary Of Other Expenses

	Description	FY 2013	FY 2014	FY 2015
Total -- All Other		**156,440,656**	**166,565,645**	**190,945,905**
Purchased Services		111,584,374	114,459,641	137,413,193
Utilities		9,736,115	10,012,328	9,572,575
Drugs		32,921,513	39,370,552	43,565,706
Insurance and Taxes		2,198,654	2,723,124	394,431
Purchased Services		**111,584,374**	**114,459,641**	**137,413,193**
620142	Restricted Fund Expense	76,633	117,503	208,885
620252	Physician Fees	20,510,257	20,661,564	20,931,912
620302	Consulting	8,018,102	1,421,495	1,089,231
620322	Legal Fees	2,393,527	3,057,657	8,823,824
620332	Audit Fees	194,406	189,312	182,998
620352	Architect & Eng Fees	182,585	360,654	613,919
620492	Time & Mat Contract	3,023,421	4,101,893	4,899,444
620502	Dietary	621,402	685,028	616,065
620522	Unscheduled Maint	4,687,799	5,182,758	4,092,044
620523	CUC Delivery/Vehicle Expense	32,607	17,732	13,351
620532	Advertising	2,555,479	2,490,627	3,074,645
620542	Purchased Services	29,055,253	31,846,157	36,829,150
620562	Purchased Maint	3,220,291	4,115,060	3,668,545
620572	Freight Charges	314,512	293,794	376,663
620573	CUC Penalties	1,425		534
620574	CUC Late Fees	4,971	7,378	4,819
620582	Collection Fees	738,913	904,813	1,258,006
620602	Lab Outside Fees	3,205,690	3,257,673	3,895,713
620622	Computer Services	4,970,519	5,156,385	5,329,474
620682	Micro Maint	74,128	60,533	53,293
620692	Equipment Rental	3,033,690	3,605,722	4,984,163
620792	Contracted Services	18,663,071	20,802,740	29,254,214
620892	Membership & Dues	1,167,871	948,989	1,218,596
620902	Special Classes	27,957	45,251	5,251
620912	Licenses & Fees	1,281,524	1,379,705	1,572,753
620922	Development Costs	176,338	406,179	503,177
620932	Professional Education	1,045,961	1,161,763	1,549,923
620933	CUC Meals & Entertainment	11,491	1,291	2,049
620952	Local Travel	323,282	287,345	330,427
620953	CUC Field Trip Expense	12,657	23,799	28,131
620982	Business Courtesy	44,274	13,444	15,270
621182	Asbestos Expense	128,761	63,639	67,203
621202	Recruiting	670,202	824,569	1,025,697
621272	Resident Education	295,055	295,284	10,154
621532	Public Relations	487,507	271,427	516,360
621972	Patient parking	217,813	213,034	367,196
622002	Med/Prof Housing Expense	115,000	187,444	114
Utilities		**9,736,115**	**10,012,328**	**9,572,575**
640702	Billed Utilities	-461,256	-576,458	-708,356

Historical Data Chart -- Summary Of Other Expenses

640712	Electricity	5,927,593	6,124,308	6,237,145
640722	Gas	1,559,592	1,848,971	1,561,890
640732	Water	1,136,971	1,195,584	1,122,990
640742	Oil	6,450	19,507	27,417
640752	Storm Water Fees	39,551	43,267	34,913
640882	Telephone	1,527,215	1,357,149	1,296,576
Drugs		**32,921,513**	**39,370,552**	**43,565,706**
630403	Drugs	32,921,513	39,370,552	43,565,706
Insurance and Taxes		**2,198,654**	**2,723,124**	**3,194,431**
670847	Self Insurance Expense	952,825	704,755	777,476
670857	Insurance	1,207,188	1,971,569	2,376,846
680878	CUC Taxes - Sales	629	178	340
680880	Gross Receipts Tax	38,012	46,622	39,769

Projected Data Chart - Summary Of Other Expenses

	Year 1	Year 2
Contract Labor	131,963	262,208
Provision for income taxes	(807,946)	76,293
Purchased Services	323,925	586,215
Professional Fees	489,495	857,781
Utilities	240,000	247,200
Repairs & Maintenance	60,000	61,800
Insurance	144,000	148,320
Enterprise Growth	96,000	98,880
Total Outside Provider Expense	0	0
Other Operating Expenses	443,925	709,815
Total	1,121,362	3,048,512

Description	Section / Item
Erlanger Interim Financial Statements	C-II-10
Erlanger Audited Financial Statements	C-II-10

Consolidated Interim Financial Statements

Quarter Ending December 31, 2015

This financial report is confidential and proprietary information. This document is not a public record until finalized and released by the chief financial officer. The embargo date for the information contained herein is January 25,2016 at 5P.M. EST. No part of the information contained herein may be released or discussed publicly until this date.

ERLANGER HEALTH SYSTEM
Unaudited Consolidated Balance Sheets as of: December 31, 2015

ASSETS	2016	2015
UNRESTRICTED FUND		
CURRENT:		
Cash and temporary Investments	$ 58,648,719	$ 48,577,896
Funds held by trustee - current portion	-	52,298
Patient accounts receivable	438,100,622	354,232,363
Less allowances for patient A/R	(327,996,012)	(276,421,074)
Net patient accounts receivable	110,104,610	77,811,289
Other receivables.	38,401,236	38,167,740
Due from third party payors	8,665,590	23,125,718
Inventories	14,387,948	12,938,442
Prepaid expenses	8,440,124	7,040,384
Total current assets	238,648,227	207,713,768
PROPERTY, PLANT, AND EQUIPMENT		
Net property, plant and equipment	157,916,925	141,112,886
LONG-TERM INVESTMENTS	249,473	602,850
OTHER ASSETS:		
Assets whose use is limited	174,512,430	202,886,315
Deferred debt issue cost	805,890	1,980,398
Other assets	1,612,580	1,632,856
Total other assets	176,930,900	206,499,568
DEFERRED OUTFLOWS OF RESOURCES		
Deferred pension adjustments	3,959,346	-
Deferred amounts from debt refunding	594,406	680,344
TOTAL	**$ 578,299,277**	**$ 556,609,415**

LIABILITIES	2016	2015
UNRESTRICTED FUND		
CURRENT:		
Current maturities of long term debt	$ 4,984,135	$ 4,566,185
Accounts payable/unearned income	48,171,346	42,896,883
Accrued salaries & related liabilities	20,046,228	17,334,117
Due to third party payors	-	1,332,482
Construction fund payable	743,413	15,111
Accrued Interest payable	2,289,743	808,308
Total current liabilities	76,234,865	66,953,086
POST RETIREMENT BENEFITS (GASB 67/68 & FAS 112)	54,558,572	28,652,013
RESERVE FOR OTHER LIABILITIES	17,901,982	20,068,640
DEFERRED INFLOWS OF RESOURCES		
Deferred pension adjustments	318,312	-
Deferred gain from sale-leaseback	3,470,969	3,935,725
LONG - TERM DEBT	207,114,126	228,436,439
FUND BALANCE:		
Unrestricted	204,174,167	201,994,358
Invested in capital assets, net of related debt	9,146,716	1,491,948
Restricted	5,379,567	5,077,206
	218,700,451	208,563,512
TOTAL	**$ 578,299,277**	**$ 556,609,415**

Erlanger Health System

Unaudited Consolidated Statement of Operations

For the quarter ended December 31, 2015 and 2014

	Current Quarter			Year to Date		
	Actual	Budget	Prior Year	Actual	Budget	Prior Year
Net patient service revenue	$ 192,769,842	$ 175,327,162	$ 166,290,317	$ 375,624,421	$ 348,596,904	$ 323,178,013
Other revenue(expense)	8,541,675	7,962,390	7,709,232	16,750,811	15,984,742	15,224,119
Net operating revenue	201,311,517	183,289,552	173,999,549	392,375,231	364,581,646	338,402,132
Expenses						
Salaries and employee benefits	99,447,463	97,749,490	83,452,576	198,277,989	194,729,395	167,388,892
Supplies	28,940,369	23,200,894	22,820,505	54,044,142	45,667,334	43,338,685
Purchased services	40,419,488	35,665,776	33,785,957	77,369,624	71,488,600	64,955,481
Utilities	2,313,367	2,463,209	2,186,592	5,207,147	4,928,918	5,005,112
Drugs	16,046,111	11,351,103	11,028,464	28,742,676	22,254,505	21,322,113
Depreciation	7,284,924	7,265,902	7,086,993	14,562,994	14,529,334	14,172,209
Insurance & taxes	737,682	1,008,068	894,328	1,697,445	1,942,945	1,752,879
Total operating expense	195,189,405	178,704,442	161,255,415	379,902,018	355,541,032	317,935,371
Excess rev. over/(under) exp. from operations	6,122,112	4,585,110	12,744,133	12,473,214	9,040,615	20,466,761
NONOPERATING INCOME:						
Gain (Losses) on disposal of assets	730,285	88,611	(217,162)	809,827	177,222	(166,783)
Interest Income/Gains (Losses) on Investments	(579,777)	183,663	258,446	(89,350)	367,326	350,306
Interest expense	(2,511,197)	(2,806,949)	(5,288,282)	(4,981,160)	(5,613,899)	(7,295,469)
Mark to market on swaps	-	-	6,997	-	-	693,533
Provisions for income tax	(178,842)	(124,870)	(24,279)	(313,308)	(252,530)	(157,830)
Excess rev. over/(under) expenses	$ 3,582,582	$ 1,925,564	$ 7,479,854	$ 7,899,222	$ 3,718,733	$ 13,890,518
Operating Margin	3.04%	2.50%	7.32%	3.18%	2.48%	6.05%
Total Margin	1.78%	1.05%	4.29%	2.01%	1.02%	3.90%

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY (d/b/a Erlanger Health System and Discretely Presented Component Units)

Audited Combined Financial Statements

Year Ended June 30, 2015

PYA

Certified Public Accountants

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Audited Combined Financial Statements

Years Ended June 30, 2015

PERSHING YOAKLEY & ASSOCIATES, P.C.
One Cherokee Mills, 2220 Sutherland Avenue
Knoxville, TN 37919
p: (865) 673-0844 | f: (865) 673-0173
www.pyapc.com

PYA
Certified Public Accountants

INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees of
Chattanooga-Hamilton County Hospital Authority
(d/b/a Erlanger Health System):

Report on the Combined Financial Statements

We have audited the accompanying combined financial statements of the business-type activities of Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System (the Primary Health System) and its discretely presented component units, as of and for the year ended June 30, 2015, and the related notes to the combined financial statements, which collectively comprise the Primary Health System's basic combined financial statements as listed in the table of contents.

Management's Responsibility for the Combined Financial Statements

Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express opinions on these combined financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Primary Health System's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness

of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities and the discretely presented component units of the Primary Health System as of June 30, 2015, and the respective changes in financial position and, where applicable, cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

As discussed in Note A to the combined financial statements, during the year ended June 30, 2015, the Primary Health System adopted a newly issued accounting standard that requires retroactive adjustments to amounts previously reported with a cumulative effect adjustment to net position as of June 30, 2014. Our opinion is not modified with respect to this matter.

Other Matters

Required Supplementary Information: Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis (shown on pages 3 through 10), the Schedule of Changes in Net Pension Liability and Related Ratios (shown on page 48) and the Schedule of Actuarial Contributions (shown on page 49) be presented to supplement the basic combined financial statements. Such information, although not a part of the basic combined financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic combined financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic combined financial statements, and other knowledge we obtained during our audit of the basic combined financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Pershing Yoakley & Associates PC

Knoxville, Tennessee
September 17, 2015

Management's Discussion and Analysis

MANAGEMENT'S DISCUSSION AND ANALYSIS

The discussion and analysis of Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System's financial performance provides an overview of financial activities for the fiscal year ended June 30, 2015.

Erlanger Health System (the Primary Health System) is the largest healthcare provider in Southeast Tennessee. The Primary Health System maintains a number of very specialized clinical services such as Level I trauma, Level III neonatal, kidney transplantation, a Regional Cancer Unit, a full service children's hospital, and open heart surgery, all of which are primarily serviced by four "Life Force" helicopters and supported by subspecialty physicians (residents, faculty and private attending physicians) located on its campuses.

OVERVIEW OF THE COMBINED FINANCIAL STATEMENTS

The combined financial statements consist of two parts: Management's Discussion and Analysis and the combined financial statements. The combined financial statements also include notes that explain in more detail some of the information in the combined financial statements.

The combined financial statements of the Primary Health System offer short-term and long-term financial information about its activities. The combined statements of net position include all of the Primary Health System's assets and liabilities and provide information about the nature and amounts of investments in resources (assets) and the obligations to the Primary Health System's creditors (liabilities). The assets and liabilities are presented in a classified format, which distinguishes between current and long-term assets and liabilities. It also provides the basis for computing rate of return, evaluating the capital structure of the Primary Health System and assessing the liquidity and financial flexibility of the Primary Health System.

All of the fiscal year's revenues and expenses are accounted for in the combined statements of revenue, expenses, and changes in net position. These statements measure the success of the Primary Health System's operations and can be used to determine whether the Primary Health System has successfully recovered all of its costs through the services provided, as well as its profitability and credit worthiness.

The final required financial statement is the combined statement of cash flows. The primary purpose of this statement is to provide information about the Primary Health System's cash receipts, cash payments and net changes in cash resulting from operating, investing, non-capital financing and financing activities. The statement also provides answers to such questions as where did cash come from, what was cash used for, and what was the change in the cash balance during the reporting period?

The analysis of the combined financial statements of the Primary Health System begins on the next page. One of the most important questions asked about the Primary Health System's finances is "Is the financial condition of the Primary Health System as a whole better or worse as a result of the fiscal year's activities?" The combined statements of net position and the combined statements of revenue, expenses and changes in net position report information about the Primary Health System's activities in a way that will help answer this question. These two statements report the net position of the Primary Health System and changes in the net position. One can think of the Primary Health System's net position – the difference between assets and liabilities – as one way to measure financial health or financial position. Over time, increases or decreases in the Primary Health System's net position is one indicator of whether its financial health is improving or deteriorating. However, one will need to consider other non-financial factors such as changes in economic conditions, regulations and new or changed government legislation.

REPORTING ENTITY

The Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System (the Primary Health System) was created by a private act passed by the General Assembly of the State of Tennessee on March 11, 1976, and adopted by a majority of the qualified voters of Hamilton County, Tennessee on August 5, 1976. The Primary Health System is considered the primary governmental unit for financial reporting purposes. As required by generally accepted accounting principles, these financial statements present the Primary Health System and its component units. The component units discussed below are included in the Primary Health System's reporting entity because of the significance of their operational, financial or other relationships with the Primary Health System.

ContinuCare HealthServices, Inc., Cyberknife of Chattanooga, LLC (Cyberknife), UT-Erlanger Medical Group, Inc. (the Medical Group) and Erlanger Health Plan Trust are legally separate organizations for which the Primary Health System is either financially accountable or owns a majority interest. Accordingly, these organizations represent component units of the Primary Health System. The financial statements of Erlanger Health Plan Trust are blended with the financial statements of the Primary Health System, as the Board of Erlanger Health Plan Trust is substantially the same as that of the Primary Health System and the Primary Health System has operational responsibility.

During fiscal year 2011, Cyberknife was capitalized by contributions from the Primary Health System and certain other minority partners. Cyberknife provides radiation therapy services, specifically robotic stereotactic radiosurgical services through the use of a Cyberknife stereotactic radiosurgery system on the Primary Health System's campus. At June 30, 2015, and 2014, the Primary Health System owned 51% of Cyberknife's outstanding membership units. The Medical Group was formed on June 30, 2011 and will provide professional healthcare and

related services to the public through its employed and contracted licensed physicians and other supporting healthcare providers. The Medical Group has no members; however, the Primary Health System may access the Medical Group's services. The Medical Group is currently not active.

KEY FINANCIAL INDICATORS

The following key financial indicators are for Erlanger Health System as a whole. They are inclusive of the Primary Health System, ContinuCare HealthServices, Inc., and the 51% controlling share of Cyberknife of Chattanooga, LLC.

- Excess revenues over expenses for Erlanger Health System for fiscal year 2015 is $37 million compared to excess of revenue over expenses of $11 million for fiscal year 2014.

- Excess revenues over expenses from operations for Erlanger Health System for fiscal year 2015 is $48 million compared to excess of revenue over expenses of $18 million for fiscal year 2014.

- Total cash and investment reserves at June 30, 2015 are $102 million (excluding $103 million in capital investment funds and $84 million of funds held by Trustees or restricted by donors or others).

- Net days in accounts receivable for Erlanger Health System (utilizing a three month rolling average of net revenue) is 47 days at June 30, 2015 compared to 50 days at June 30, 2014.

- For fiscal year 2015, Erlanger Health System recognized $18.8 million in public hospital supplemental payments from the State of Tennessee compared to $19.6 million in fiscal year 2014.

- For fiscal year 2015, Erlanger Health System recognized $17.4 million in essential access payments from the State of Tennessee compare to $12.8 million in fiscal year 2014 compared to $12.8 million in fiscal year 2014.

- For both fiscal year 2015 and 2014, Erlanger Health System did not recognize disproportionate share payments from the State of Tennessee.

- For fiscal year 2015, Erlanger Health System recognized $1.1 million in trauma fund payments from the State of Tennessee compared to $0.9 million in fiscal year 2014.

The required bond covenant ratios for fiscal year 2015 compared to bond requirements are as follows:

			Bond Insurer Requirements	
	June 30, 2015	Master Trust Indenture	14 Series	04 Series
Debt service coverage ratio	5.41	1.10	1.35	1.35
Current ratio	2.67	N/A	1.50	1.50
Days cash on hand	104	N/A	65 days	65 days
Indebtedness ratio	52%	N/A	65%	65%

The trust indentures and related documents underlying the bonds contain certain covenants and restrictions. For fiscal year 2015, Erlanger Health System met all required debt covenants.

NET POSITION

Erlanger Health System's net position for the combined Primary Health System and Aggregate Discretely Presented Component Units increased by approximately $37.6 million in fiscal year 2015. Our analysis focuses on the net position (Table 1) and changes in net position (Table 2) of the Primary Health System's operating activities. Discussion focuses on the Primary Health System and its blended component units.

Net position for the Primary Health System increased from $195 million as of June 30, 2014 to $211 million as of June 30, 2015. The current ratio (current assets divided by current liabilities) increased from 2.52 in 2014 to 2.67 in 2015 for the Primary Health System.

Table 1- Net Position (in Millions)

	June 30, 2015		June 30, 2014	
	Primary Health System	Discretely Presented Component Units	Primary Health System	Discretely Presented Component Units
Current and other assets	$ 442	$ 13	$ 332	$ 12
Capital assets	142	8	149	9
Total assets	585	21	480	21
Deferred ouflows of resources	6	-	1	-
	$ 590	$ 21	$ 481	$ 21

	June 30, 2015		*June 30, 2014*	
	Primary Health System	***Discretely Presented Component Units***	***Primary Health System***	***Discretely Presented Component Units***
Long-term debt outstanding	**$ 213**	**$ -**	$ 159	$ 4
Other liabilities	**163**	**6**	123	3
Total liabilities	**376**	**6**	282	7
Deferred inflows of resources	**4**	**-**	4	-
	$ 380	**$ 6**	$ 286	$ 7
Net position				
Net investment in capital assets	**$ 2**	**$ 5**	$ 1	$ 5
Restricted, expendable	**3**	**-**	2	-
Unrestricted	**206**	**10**	191	9
Total net position	**$ 210**	**$ 15**	$ 194	$ 14

Days in cash increased from 88 days as of June 30, 2014 to 104 days as of June 30, 2015 for the Primary Health System resulting from increased operating margins.

Days in net accounts receivable for the Primary Health System were 51 days as of June 30, 2015 and 2014.

Capital assets for the Primary Health System were $142 million as of June 30, 2015. Additions for fiscal year 2015 totaled $18 million while $16 million of assets were retired or sold. Depreciation expense was $25 million for the Primary Health System. Retirement of assets reduced accumulated depreciation by $11 million in fiscal year 2015. Construction in progress was $11 million as of June 30, 2015. Included in construction in progress is the Erlanger East expansion totaling $5.7 million.

Long-term debt outstanding amounted to $213 million as of June 30, 2015 compared to $159 million as of June 30, 2014. The increase in long-term debt reflects $71 million of new money included in the Series 2014 Bonds.

Other liabilities for the Primary Health System were $163 million as of June 30, 2015 compared to $123 million as of June 30, 2014, due in part to the recognition of the pension liability required by a new accounting standard.

CHANGES IN NET POSITION

The focus for Erlanger Health System's management team during fiscal year 2015 was to increase the Primary Health System's volumes in a number of key product lines in a flat market, improve relationships with stakeholders, and improve operating efficiencies.

Table 2- Changes in Net Position (in Millions)

	June 30, 2015		*June 30, 2014*	
	Primary Health System	***Discretely Presented Component Units***	***Primary Health System***	***Discretely Presented Component Units***
Net patient revenue	$ 670	$ 11	$ 571	$ 11
Other revenue	16	18	21	17
Total revenue	686	29	592	28
Expenses:				
Salaries	333	14	305	14
Supplies and other expenses	140	10	126	10
Purchased services	141	3	117	3
Depreciation and amortization	25	1	26	1
Total expenses	638	28	574	28
Operating income revenues in excess of (less than) expenses	47	1	18	1
Nonoperating gains	2	-	2	-
Interest expense and other	(12)	-	(9)	-
Operating/capital contributions	0	-	1	-
Change in net position	$ 38	$ 1	$ 12	$ 1

Net patient service revenue for the Primary Health System increased from $571 million in fiscal year 2014 to $670 million in fiscal year 2015. Admissions for fiscal year 2015 were 33,340 compared to 30,394 for fiscal year 2014, a 9.7% increase. Observation days decreased from 8,398 for fiscal year 2014 to 7,836 for fiscal year 2015, or by 6.7%. Air ambulance flights increased from 1,870 flights for fiscal 2014 to 1,994 flights for fiscal year 2015, or by 6.6%. Medicare case mix index was 1.88 for fiscal years 2014 and 2015. Total surgical inpatients increased from 9,198 for fiscal year 2014 to 9,856 for fiscal 2015, or by 7.2%. Total surgical outpatients for fiscal year 2015 increased by 4.0% over the prior year. Total emergency room visits were 150,851 for fiscal year 2015, a 14.3 % increase over fiscal year 2014.

Salaries for the Primary Health System increased from $305 million in fiscal year 2014 to $333 million in fiscal year 2015. Staffing was in concert with the increased volumes. Paid FTE's per adjusted occupied bed decreased from 5.1 in fiscal year 2014 to 4.8 in fiscal year 2015, however, salary cost for fiscal year 2015 per hour increased by 8.6% over the prior year. A 2% raise for full time employees (excluding bedside nurses) was implemented in January 2015 and a 2.7% market adjustment for bedside nurses was implemented in July 2014. The post-retirement benefits were discontinued in January 2015.

Supplies and other expenses increased from $126 million for fiscal year 2014 to $140 million in fiscal year 2015. Supplies and drug costs trended with the volume increases. Supplies and drugs per adjusted admission for the Primary Health System increased from $1,555 in fiscal year 2014 to $1,573 in fiscal year 2015.

Purchased Services increased from $117 million in fiscal year 2014 to $141 million in fiscal year 2015 due in part to an increase in contracted hospitalist fees resulting from increased volumes.

Depreciation and amortization expense decreased from $26 million in fiscal year 2014 to $25 million in fiscal year 2015 based on the capital spending plan.

Interest expense, including gain (or loss) on mark-to-market of interest rate swaps in 2014, increased from $9 million in fiscal year 2014 to $12 million in fiscal year 2015. The Series 2014 Bonds issued in December 2014 resulted in $71 million in additional debt. The interest rate swaps agreements were terminated in fiscal year 2015.

OUTLOOK

The State of Tennessee continues to review the TennCare program (the State's Medicaid program). For fiscal years 2012 and 2013, the State passed a Hospital Coverage Fee to offset shortfalls in the State's budget for TennCare. The fee remained intact and TennCare rates were stable in fiscal year 2014 and 2015. There could be possible TennCare rate changes in fiscal year 2016 as a result of rate variation initiatives. Out-of-state Medicaid and TennCare changes would affect the Primary Health System's bottom line with TennCare and Medicaid patients representing approximately 23% of the payer mix. Self-pay patients represent approximately 8% of the charge utilization. Healthcare reform and future changes in Medicare regulations could also have an adverse effect on the Primary Health System's future operations since Medicare represents approximately 33% of the payer mix.

During fiscal year 2014, the Primary Health was added as a participant to the Public Hospital Supplemental Payment Pool for public hospitals in Tennessee through a collaborative effort with local Mayors, State Senators and Representatives, Hamilton County Medical Society, Board members, physicians and hospital leadership. The inclusion of the Primary Health System in the

pool netted $19.6 million of additional federal funding for fiscal year 2014 and $18.8 million for fiscal year 2015. The Primary Health System will receive this funding annually as long as the current TennCare waiver is intact.

The Primary Health System recognized Essential Access payments totaling $17.4 million from the State of Tennessee for fiscal year 2015, an increase of $4.6 million from fiscal year 2014. Disproportionate share payments were not approved by Federal government for fiscal year 2014 and funds received during 2015 have not been recognized until eligibility is determined. Additionally, the Primary Health System recognized trauma funding of $1.1 million in fiscal year 2015 compared to $0.9 million in fiscal year. Payments from the State of Tennessee for the fiscal year 2016 are expected to be consistent with the fiscal year 2015. Due to the 1966 Hamilton County Sales Tax Agreement expiring in May 2011, the Hamilton County appropriations to the Primary Health System have been reduced from $3 million to $1.5 million.

The focus of Erlanger Health System's CEO and leadership team for fiscal year 2015 has been top-line, sustainable growth, cost containment and strengthened physician relations. The strategic plans put in place this fiscal year have yielded strong positive results and enabled investment in Erlanger and the community. The health system has infused $71 million from bond sales into major growth initiatives.

Audited Combined Financial Statements

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Net Position

	June 30, 2015	
	Primary Health System	*Discretely Presented Component Units*
ASSETS		
CURRENT ASSETS:		
Cash and cash equivalents	$ 92,642,502	$ 1,072,363
Temporary investments	3,258,275	5,637,906
Patient accounts receivable, net	93,787,459	2,040,568
Estimated amounts due from third party payers	5,399,871	-
Due from other governments	130,037	409,825
Inventories	12,991,042	1,299,621
Receivable from Hutcheson Medical Center	20,000,000	-
Other current assets	11,832,273	1,563,932
TOTAL CURRENT ASSETS	240,041,459	12,024,215
NET PROPERTY, PLANT AND EQUIPMENT	142,126,358	8,459,744
LONG-TERM INVESTMENTS, for working capital	324,862	-
ASSETS LIMITED AS TO USE	186,519,439	-
OTHER ASSETS:		
Prepaid bond insurance	890,721	-
Equity in discretely presented component units	14,478,062	-
Other assets	189,079	557,145
TOTAL OTHER ASSETS	15,557,862	557,145
TOTAL ASSETS	584,569,980	21,041,104
DEFERRED OUTFLOWS OF RESOURCES		
Deferred pension adjustments	3,959,346	-
Deferred amounts from debt refunding	1,724,071	-
TOTAL DEFERRED OUTFLOWS OF RESOURCES	5,683,417	-
COMBINED ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 590,253,397	$ 21,041,104

See notes to combined financial statements.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Net Position - Continued

	June 30, 2015	
	Primary Health System	***Discretely Presented Component Units***
LIABILITIES		
CURRENT LIABILITIES:		
Accounts payable and accrued expenses	$ 52,923,265	$ 1,361,173
Accrued salaries and related liabilities	25,723,976	1,099,831
Due to other governments	409,825	130,037
Current portion of long-term debt and capital lease obligations	4,782,194	3,036,295
Other current liabilities	7,456,250	178,113
TOTAL CURRENT LIABILITIES	91,295,510	5,805,449
LONG-TERM DEBT AND CAPITAL LEASE OBLIGATIONS	213,102,723	110,221
NET PENSION LIABILITY	51,857,463	-
OTHER LONG-TERM LIABILITIES	19,496,243	-
TOTAL LIABILITIES	375,751,939	5,915,670
DEFERRED INFLOWS OF RESOURCES		
Deferred pension adjustments	318,312	-
Deferred gain from sale-leaseback	3,470,969	-
TOTAL DEFERRED INFLOWS OF RESOURCES	3,789,281	-
NET POSITION:		
Unrestricted	205,862,075	9,755,724
Net investment in capital assets	1,838,341	5,369,710
Restricted expendable:		
Health plan trust	1,623,416	-
Donor restricted	1,388,345	-
TOTAL NET POSITION	210,712,177	15,125,434
COMBINED LIABILITES, DEFERRED OUTFLOWS OF RESOURCES AND NET POSITION	$ 590,253,397	$ 21,041,104

See notes to combined financial statements.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Changes in Net Position

	Year Ended June 30, 2015	
	Primary Health System	*Discretely Presented Component Units*
OPERATING REVENUE:		
Charges for services:		
Net patient service revenue	$ 669,863,550	$ 11,263,001
Other revenue	15,712,983	18,208,040
TOTAL OPERATING REVENUE	685,576,533	29,471,041
OPERATING EXPENSES:		
Salaries, wages and benefits	332,652,156	14,063,605
Supplies and other expenses	136,259,730	10,499,399
Purchased services	140,782,277	2,516,607
Insurance and taxes	3,479,089	352,441
Depreciation	25,125,088	1,148,854
TOTAL OPERATING EXPENSES	638,298,340	28,580,906
OPERATING INCOME	47,278,193	890,135
NONOPERATING REVENUE (EXPENSES):		
Gain on disposal of assets	311,556	185,913
Interest and investment income, net of fees	534,193	(26,043)
Net gain from discretely presented component units	353,793	-
Interest expense	(11,828,171)	(154,532)
Provision for income taxes	-	(407,086)
Change in mark-to-market of interest rate swaps	693,533	-
NET NONOPERATING REVENUE (EXPENSES)	(9,935,096)	(401,748)
INCOME BEFORE CONTRIBUTIONS	37,343,097	488,387
Operating distribtuions	(25,142)	-
Capital contributions	301,429	-
CHANGE IN NET POSITION	37,619,384	488,387
NET POSITION AT BEGINNING OF YEAR, as previously reported	194,553,424	14,637,047
CUMULATIVE EFFECT OF CHANGE IN ACCOUNTING PRINCIPLE	(21,460,631)	-
NET POSITION AT BEGINNING OF YEAR	173,092,793	14,637,047
NET POSITION AT END OF YEAR	$ 210,712,177	$ 29,762,481

See notes to combined financial statements.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statement of Cash Flows

Primary Health System	*Year Ended June 30 2015*
CASH FLOWS FROM OPERATING ACTIVITIES:	
Receipts from third-party payers and patients	$ 663,337,934
Payments to vendors and others for supplies, purchased services, and other expenses	(268,727,175)
Payments to and on behalf of employees	(321,733,330)
Other receipts	16,154,086
NET CASH PROVIDED BY OPERATING ACTIVITIES	89,031,515
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES:	
Contributions	(25,142)
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:	
Acquisition and construction of capital assets, net	(23,837,648)
Proceeds from sale of assets	4,978,206
Principal paid on bonds, capital lease obligations and other	(15,492,190)
Proceeds from issuance of long-term debt	171,465,880
Payments to defease bonds	(109,805,916)
Interest payments on long-term debt	(9,507,644)
Swap termination payment	(3,289,113)
Capital contributions	301,429
NET CASH PROVIDED BY CAPITAL AND RELATED FINANCING ACTIVITIES	14,813,004
CASH FLOWS FROM INVESTING ACTIVITIES:	
Interest, dividends, and net realized gains (losses) on investments	534,193
Change in temporary and long-term investments for working capital	(1,872,133)
Payments received on note receivable	550,000
Net cash transferred to assets limited as to use	(54,590,999)
NET CASH USED IN INVESTING ACTIVITIES	(55,378,939)
INCREASE IN CASH AND CASH EQUIVALENTS	48,440,438
CASH AND CASH EQUIVALENTS AT BEGINNING OF YEAR	44,202,064
CASH AND CASH EQUIVALENTS AT END OF YEAR	$ 92,642,502

See notes to combined financial statements.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statement of Cash Flows - Continued

Primary Health System	*Year Ended June 30 2015*
RECONCILIATION OF OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES:	
Operating income	**$ 47,278,193**
Adjustments to reconcile operating income to net cash provided by operating activities:	
Depreciation	**25,125,088**
Changes in assets and liabilities:	
Patient accounts receivable, net	**(14,358,498)**
Estimated amounts due from third party payers, net	**6,009,092**
Inventories and other assets	**1,126,630**
Accounts payable and accrued expenses	**10,975,005**
Accrued salaries and related liabilities	**10,918,826**
Other current and long-term liabilities	**1,957,179**
NET CASH PROVIDED BY OPERATING ACTIVITIES	**$ 89,031,515**

See notes to combined financial statements.

NOTE A--SIGNIFICANT ACCOUNTING POLICIES

Reporting Entity: The Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System (the Primary Health System) was created by a private act passed by the General Assembly of the State of Tennessee on March 11, 1976, and adopted by a majority of the qualified voters of Hamilton County, Tennessee on August 5, 1976. The Chattanooga-Hamilton County Hospital Authority consists of the Primary Health System and its aggregate discretely presented component units as disclosed below.

The Primary Health System provides comprehensive healthcare services throughout Hamilton and Bledsoe counties, as well as outlying areas in southeastern Tennessee and north Georgia. These services are provided primarily through the hospital and other facilities located on the Baroness campus of Erlanger Medical Center. The Primary Health System also operates other hospitals and clinics throughout the area. The Primary Health System is considered the primary governmental unit for financial reporting purposes. As required by accounting principles generally accepted in the United States of America, these combined financial statements present the Primary Health System and its component units. The component units discussed below are included in the Primary Health System's reporting entity because of the significance of their operational or financial relationships with the Primary Health System.

The primary mission of the Primary Health System and its component units is to provide healthcare services to the citizens of Chattanooga, Hamilton County and the surrounding area. Only those activities directly associated with this purpose are considered to be operating activities. Other activities that result in gains or losses unrelated to the Primary Health System's primary mission are considered to be nonoperating.

Erlanger Health Plan Trust, ContinuCare HealthServices, Inc., Cyberknife of Chattanooga, LLC, and UT-Erlanger Medical Group, Inc. are legally separate organizations which the Primary Health System has determined are component units of the Primary Health System.

Blended Component Units: The financial statements of Erlanger Health Plan Trust include assets limited as to use totaling $1,623,416 as of June 30, 2015 and net investment loss totaling $3,617 for the year ended June 30, 2015 that are blended in the combined financial statements of the Primary Health System. The board of the Erlanger Health Plan Trust is substantially the same as that of the Primary Health System and the Primary Health System has operational responsibility.

Discretely Presented Component Units: The discretely presented component units' column in the combined financial statements includes the financial data of the Primary Health System's other component units. They are reported in a separate column to emphasize that they are legally

separate from the Primary Health System. See the combined, condensed financial information in Note Q.

1. ContinuCare HealthServices, Inc. and subsidiary (ContinuCare) provide health and supportive services to individuals in their homes in the Hamilton County and north Georgia areas. ContinuCare also provides retail pharmacy goods and services at four locations in Hamilton County. The Primary Health System owns 100% of the stock of ContinuCare. Separately audited financial statements for ContinuCare HealthServices, Inc. may be obtained by mailing a request to 1501 Riverside Drive, Suite 140, Chattanooga, Tennessee 37406.

2. Cyberknife of Chattanooga, LLC (Cyberknife) provides radiation therapy services, specifically robotic stereotactic radiosurgical services, through the use of a cyberknife stereotactic radiosurgery system on the Primary Health System's campus. The Primary Health System owns 51% of Cyberknife's outstanding membership units and Cyberknife is fiscally dependent on the Primary Health System.

   A condition of admission as a Member of Cyberknife, is to deliver limited guaranties, guaranteeing pro-rata repayment of indebtedness of Cyberknife incurred to finance its equipment costs and its working capital needs. As of June 30, 2015, total debt outstanding was $3,092,057 with payments due through 2017. Management believes that the Primary Health System will not be required to make any payments related to the guarantee of this indebtedness.

3. UT-Erlanger Medical Group, Inc. (the Medical Group) was formed on June 30, 2011 and will provide professional healthcare and related services to the public through employed and contracted licensed physicians and other supporting healthcare providers. The Medical Group has no members; however, the Primary Health System may access the Medical Group's services. The Primary Health System is not entitled to any potential earnings of the Medical Group except for compensation for services rendered to the Medical group on its behalf. However, based upon the significance of the Medical Group's potential operation to the Primary Health System, management believes its exclusion would be misleading and as such, includes the Medical Group as a component unit. The Medical Group is currently not active.

Erlanger Health System Foundations (the Foundation): The Foundation assists the Primary Health System to promote and develop charitable and educational opportunities as they relate to healthcare services provided by the Primary Health System. The Primary Health System is not financially accountable for the Foundation and as a result, the Foundation has not been included in the combined financial statements.

Contributions from the Foundation totaling approximately $32,000 for the year ended June 30, 2015 were recognized as contribution revenue by the Primary Health System. The Primary Health System provided support to the Foundation of $594,000 in 2015.

Use of Estimates: The preparation of the combined financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the combined financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

Enterprise Fund Accounting: The Primary Health System and its blended component units utilize the enterprise fund method of accounting whereby revenue and expenses are recognized on the accrual basis using the economic resources measurement focus.

Recently Issued or Effective Accounting Pronouncements: In June 2012, the Governmental Accounting Standards Board (GASB) issued Statement No. 68, *Accounting and Financial Reporting for Pensions*. Statement No. 68 provides guidance for improved accounting and financial reporting by state and local government entities related to pensions. It also replaces the requirements of GASB Statement No. 27 and Statement No. 50, as they relate to pensions that are provided through pension plans administered as trusts or equivalent arrangements that meet certain criteria. Additionally, the GASB issued Statement No. 71, *Pension Transition for Contributions Made Subsequent to the Measurement Date*, which is effective concurrent with Statement No. 68. Among other requirements, the Primary Health System recorded a net pension liability that is based on fiduciary plan net position rather than on plan funding. The Primary Health System adopted these Statements in 2015 and a cumulative effect adjustment has been recorded as a restatement of net assets as of June 30, 2014 in the combined financial statements.

In February 2015, the GASB issued Statement No. 72, *Fair Value Measurement and Application*. Statement No. 72 defines fair value and describes how fair value should be measured, what assets and liabilities should be measured at fair value, and what information about fair value should be disclosed in the notes to the financial statements. This statement will become effective in fiscal 2016 and management does not expect any significant impact on the combined financial statements other than additional disclosures.

Net Patient Service Revenue/Receivables: Net patient service revenue is reported on the accrual basis in the period in which services are provided at rates which reflect the amount expected to be collected. Net patient service revenue includes amounts estimated by management to be reimbursable by third-party payer programs under payment formulas in effect. Net patient

revenue also includes an estimated provision for bad debts based upon management's evaluation of collectability based upon the age of the receivables and other criteria, such as payer classification and management's assumptions about conditions it expects to exist and courses of action it expects to take. The Primary Health System's policies do not require collateral or other security for accounts receivable, although the Primary Health System routinely accepts assignment or is otherwise entitled to receive patient benefits payable under health insurance programs, plans or policies. Supplemental payments from the State of Tennessee are recognized when determinable (see Note B).

Charity Care: The Primary Health System accepts patients regardless of their ability to pay. A patient is classified as a charity patient by reference to certain policies established by the County Auditor with regard to the Hamilton County indigent program or by the Primary Health System for other patients. Essentially, these policies define charity services as those services for which minimal payment is anticipated. In assessing a patient's inability to pay, the County and the Primary Health System utilize the generally recognized poverty income levels, but also include certain cases where incurred charges are significant when compared to the income of the patient. These charges are not included in net patient service revenue.

Cash Equivalents: The Primary Health System considers all highly liquid investments with maturities of three months or less when purchased, excluding amounts whose use is limited by board designation, held by trustees under indenture agreement, or otherwise restricted as to use, to be cash equivalents.

Inventories: Inventories consist principally of medical and surgical supplies, general store supplies, and pharmacy items and are stated at lower of cost (first-in, first-out) or fair market value.

Investments: The Primary Health System's investments (including assets limited as to use) are reported at fair market value based on quoted market prices. Assets limited as to use include funds designated by the Board, funds held by trustees under trust indentures, and funds restricted by donors or grantors for specific purposes. The Primary Health System considers those investments with maturities of more than three months when purchased, maturing in more than one year and whose use is not limited by board designation, held by trustees under indenture agreement, or otherwise restricted as to use, to be long-term investments.

Temporary Investments: The Primary Health System considers all highly liquid investments with maturities of more than three months when purchased and maturing in less than one year, excluding amounts whose use is limited by board designation, held by trustees under indenture agreement, or otherwise restricted as to use, to be temporary investments.

Net Property, Plant and Equipment: Property, plant and equipment is recorded on the basis of cost. Donated assets are recorded at their fair market value at the date of donation. Leases that are substantially installment purchases of property are recorded as assets and amortized over their estimated useful lives ranging from three to thirty years; related amortization is included in depreciation expense. Depreciation expense is computed over estimated service lives of the respective classes of assets using the straight-line method. The Primary Health System has established a capitalization threshold for property, plant and equipment of $2,500 except for computer equipment, which has a threshold of $1,000. Interest expense and interest income on borrowed funds related to construction projects are capitalized during the construction period, if material. Costs of maintenance and repairs are charged to expense as incurred.

The Primary Health System reviews the carrying value of capital assets if facts and circumstances indicate that recoverability may be impaired. A capital asset is considered impaired when its service utility has declined significantly and unexpectedly. The Primary Health System did not experience any prominent events or changes in circumstances affecting capital assets which would require determination as to whether impairment of a capital asset has occurred during the year ended June 30, 2015.

Prepaid Bond Insurance: Financing costs related to insurance associated with bond issues are being amortized over the terms of the respective debt issues by the effective interest method.

Compensated Absences: The Primary Health System recognizes an expense and accrues a liability for employees' paid annual leave and short-term disability in the period in which the employees' right to such compensated absences is earned. Liabilities expected to be paid within one year are included as accrued salaries and related liabilities in the accompanying combined statements of net position.

Derivative Instruments: The Primary Health System records all derivatives as assets or liabilities on the combined statements of net position at estimated fair value and includes credit value adjustments. The Primary Health System's derivative holdings consisted of interest rate swap agreements. Since these derivatives have not been determined to be effective, the gain or loss resulting from changes in the fair value of the derivatives is recognized in the accompanying combined statement of revenue, expenses and changes in net position. The Primary Health System's objectives in using derivatives are to take advantage of the differences between taxable and tax-exempt debt, and manage exposure to interest rate risks associated with various debt instruments (see Note N).

Pensions: Pension amounts (net pension liability, deferred outflows of resources and deferred inflows of resources related to pensions, and pension expense, fiduciary net position of the Primary Health System's pension plan and additions to or deductions from the plan's fiduciary

net position) have been determined on the same basis as they are reported by the Primary Health System. For this purpose, benefit payments are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value

Income Taxes: The Primary Health System is exempt from income taxes under Section 501(a) as an organization described in Section 501(c)(3) of the Internal Revenue Code (IRC). In addition, it qualifies for exemption from federal income taxes pursuant to IRC Section 115 as an instrumentality of the State of Tennessee. Therefore, no provision for income taxes has been recognized in the accompanying combined financial statements for the Primary Health System.

As a for-profit entity, ContinuCare is subject to state and federal income taxes. ContinuCare HealthServices, Inc. and its subsidiary file consolidated federal income tax returns separately from the Primary Health System. At June 30, 2015, ContinuCare had no significant uncertain tax positions. Tax returns for the years ended June 30, 2010 through 2014 are subject to examination by taxing authorities.

As a limited liability corporation, Cyberknife, is subject to State of Tennessee income taxes. At June 30, 2015 Cyberknife had no significant uncertain tax positions. Tax returns for the years ended June 30, 2010 through 2014 are subject to examination by taxing authorities.

Contributed Resources: Resources restricted by donors for specific operating purposes are held as restricted funds and are recognized as operating or capital contributions in the accompanying combined financial statements. When expended for the intended purpose, they are reported as operating distributions and are recognized as other operating revenue. When an expense is incurred for purposes for which both restricted and unrestricted resources are available, restricted resources are used first. Contributed resources consist of amounts restricted by donors for specific purposes. Fundraising expenses are netted against contributions recognized.

Net Position: The net position of the Primary Health System is classified into three components. *Net investment in capital assets* consists of capital and other assets net of accumulated depreciation and reduced by the current balances of any outstanding borrowings used to finance the purchase or construction of those assets. The *restricted expendable* net position consists of assets that must be used for a particular purpose that are either externally imposed by creditors, grantors, contributors or laws or regulations of other governments or imposed by law through constitutional provisions or enabling legislation. *The unrestricted net position* is remaining assets that do not meet the definition of *net investment in capital assets* or *restricted expendable.*

Fair Value of Financial Instruments: The carrying amounts reported in the combined statements of net position approximate fair value except as described below.

The carrying value of long-term debt and capital lease obligations (including the current portion) was $217,884,917 as of June 30, 2015. The estimated fair value of long-term debt and capital lease obligations (including current portion) was $223,253,248 at June 30, 2015. The fair value of long-term debt related to fixed interest long-term debt and capital lease obligations was estimated using discounted cash flows, based on the Primary Health System's incremental borrowing rates or from quotes obtained from investment advisors. The fair value of long-term debt related to variable rate debt approximates its carrying value.

Subsequent Events: The Primary Health System evaluated all events or transactions that occurred after June 30, 2015 through September 17, 2015 , the date the combined financial statements were available to be issued.

NOTE B--NET PATIENT SERVICE REVENUE

A reconciliation of the amount of services provided to patients at established rates by the Primary Health System to net patient service revenue as presented in the combined statements of revenue, expenses and changes in net position for the year ended June 30, 2015 is as follows:

	Primary Health System
Inpatient service charges	$ 1,231,642,020
Outpatient service charges	934,797,502
Gross patient service charges	2,166,439,522
Less: Contractual adjustments and other discounts	1,311,598,641
Charity care	92,023,486
Estimated provision for bad debts	92,953,845
	1,496,575,972
Net patient service revenue	$ 669,863,550

Charity Care and Community Benefit: The Private Act of the State of Tennessee establishing the Primary Health System obligates the Primary Health System to make its facilities and patient care programs available to the indigent residents of Hamilton County to the extent of funds appropriated by Hamilton County and adjusted operating profits, as defined. The annual appropriation from Hamilton County totaled $1,500,000 for fiscal year 2015. Total charity care charges for services provided to the certified indigent residents of Hamilton County (net of the appropriation) were approximately $7,373,000 for the year ended June 30, 2015 for the Primary Health System.

In addition to charity care provided to specific patients within the hospital setting, the Primary Health System also provides unreimbursed services to the community which includes free and low cost health screenings. The Primary Health System also hosts health fairs and helps sponsor many other events that are free to the public and are spread throughout the year in various community locations.

The Primary Health System's Community Relations department includes HealthLink Plus, a free adult membership program with over 13,000 members in the Chattanooga Statistical Metropolitan Service Area. The Community Relations department hosts several free community events throughout the year utilizing the services of physicians, nurses, volunteers, educators, registered dietitians, social workers, secretaries and management personnel of the Primary Health System.

The Primary Health System's consumer call center, Erlanger HealthLink (423-778-LINK) is a free call center staffed by RN's to answer health questions, offer free physician referrals and to register participants in the programs offered by Community Relations, Women's & Infant Services and other departments and divisions of the Primary Health System.

Uncompensated Care Costs: The following table summarizes the estimated total uncompensated care costs (based on the ratio of total operating revenue and expenses) provided by Erlanger Medical Center as defined by the State of Tennessee for the year ended June 30, 2015:

Uncompensated cost of TennCare/Medicaid	$	31,782,618
Traditional charity uncompensated costs		26,681,372
Bad debt cost		26,649,921
Total estimated uncompensated care costs	$	85,113,911

The uncompensated cost of TennCare/Medicaid is estimated by taking the estimated cost of providing care to the TennCare/Medicaid patients less payments from the TennCare and Medicaid programs. The payments exclude revenues from essential access and other, one-time supplemental payments from TennCare of approximately $17,415,000 for the year ended June 30, 2015 and such payments are not guaranteed for future periods.

Revenue from Significant Payers: Gross patient service charges related to the Medicare program accounted for approximately 31.6% of the Primary Health System's patient service charges for the year ended June 30, 2015. Gross patient service charges related to the TennCare/Medicaid programs accounted for approximately 22.6% of the Primary Health System's patient service charges for the year ending June 30, 2015. TennCare typically reimburses providers at an amount less than their cost of providing services to TennCare patients. At June 30, 2015, the

Primary Health System has a credit concentration related to the Medicare and TennCare programs.

During 2015, the Primary Health System recognized revenue from these programs related to trauma fund payments of approximately $1,111,000. Further, during 2015, the Primary Health System received disproportionate share payments of approximately $5,030,000 which have not been recognized as revenue. All such amounts will be recognized when the Primary Health System's eligibility to receive such funds has been confirmed. Such amounts are subject to audit and future distributions under these programs are not guaranteed. In 2015 the Primary Health System also received and recognized a net payment of $18,781,788 from the Public Hospital Supplemental Payment Pool. Such amounts are expected to be received as long as the current TennCare waiver is intact.

Laws and regulations governing the Medicare and TennCare/Medicaid programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates, as they relate to revenue recognized from these programs, will change by a material amount in the near term. The estimated reimbursement amounts are adjusted in subsequent periods as cost reports are prepared and filed and as final settlements are determined. Final determination of amounts earned under prospective payment and cost reimbursement activities is subject to review by appropriate governmental authorities or their agents. Management believes that adequate provisions have been made for adjustments that may result from final determination of amounts earned under Medicare and Medicaid programs. The effect of prior year cost report settlements, or changes in estimates, decreased net patient service revenue by approximately $1,770,000 in 2015.

The Primary Health System has also entered into reimbursement agreements with certain commercial insurance companies, health maintenance organizations and preferred provider organizations. The basis for reimbursement under these agreements includes prospectively determined rates, per diems and discounts from established charges.

NOTE C--CASH AND CASH EQUIVALENTS

Cash and cash equivalents reported on the combined statements of net position include cash on hand and deposits with financial institutions including demand deposits and certificates of deposit, as well as, money market accounts that are held in investment accounts and meet the definition of a cash equivalent.

Cash and cash equivalents consist of the following:

	Primary Health System
Demand deposits	$ 90,410,005
Cash on hand	11,479
Cash equivalents	2,221,018
	$ 92,642,502

Bank balances consist of the following at June 30, 2015:

	Primary Health System
Insured (FDIC)	$ 599,794
Collateralized under the State of Tennessee Bank Collateral Pool	90,481,991
	$ 91,081,785

The Primary Health System's deposits would be exposed to custodial credit risk if they are not covered by depository insurance and the deposits are uncollateralized or are collateralized with securities held by the pledging financial institution's trust department or agent but not in the depositor government's name. The risk is that, in the event of the failure of a depository financial institution, the Primary Health System will not be able to recover deposits or will not be able to recover collateral securities that are in the possession of an outside party.

NOTE D--DISAGGREGATION OF RECEIVABLE AND PAYABLE BALANCES

Patient Accounts Receivable, Net: Patient accounts receivable and related allowances are as follows at June 30, 2015:

	Primary Health System
Gross patient accounts receivable	$ 359,183,176
Estimated allowances for contractual adjustments and uncollectible accounts	(265,395,717)
Net patient accounts receivable	$ 93,787,459

Other Current Assets: Other current assets consist of the following at June 30, 2015:

	Primary Health System
Prepaid expenses	$ 4,319,594
Other receivables	7,512,679
Total other current assets	$ 11,832,273

Accounts Payable and Accrued Expenses: Accounts payable and accrued expenses consist of the following at June 30, 2015:

	Primary Health System
Due to vendors	$ 48,638,243
Other	4,285,022
Total accounts payable and accrued expenses	$ 52,923,265

Other Long-Term Liabilities: Other long-term liabilities, and the related activity, consist of the following:

	Balance at Beginning of Year	*Unearned Revenue Recognized*	*Payments /Other*	*Balance at End of Year*
Compensated absences	$ 10,638,408	$ -	$ -	$ 10,638,408
Medical malpractice	5,066,000	-	(131,100)	4,934,900
Job injury program	1,253,139	-	-	1,253,139
Interest rate swaps	3,982,646	-	(3,982,646)	-
Deferred revenue	2,973,643	(393,607)	-	2,580,036
Other	-	-	89,760	89,760
Total other long-term liabilities	$ 23,913,836	$ (393,607)	$ (4,023,986)	$ 19,496,243

NOTE E--NET PROPERTY, PLANT AND EQUIPMENT

Net property, plant and equipment activity for the Primary Health System consisted of the following:

	Balance at June 30, 2014	*Additions*	*Reductions/ Transfers*	*Balance at June 30, 2015*
Capital assets:				
Land and improvements	$ 25,966,917	$ 152,048	$ (5,126,037)	$ 20,992,928
Buildings	233,622,494	2,986,741	(6,858,056)	229,751,179
Equipment	376,690,494	15,058,319	(4,369,827)	387,378,986
	636,279,905	18,197,108	(16,353,920)	638,123,093
Accumulated depreciation :				
Land and improvements	(12,072,718)	(332,824)	3,624,843	(8,780,699)
Buildings	(176,094,670)	(6,341,721)	3,389,921	(179,046,470)
Equipment	(304,859,236)	(18,450,543)	4,207,750	(319,102,029)
	(493,026,624)	(25,125,088)	11,222,514	(506,929,198)
Capital assets net of accumulated depreciation	143,253,281	(6,927,980)	(5,131,406)	131,193,895
Construction in progress	5,291,923	18,338,139	(12,697,599)	10,932,463
	$ 148,545,204	$ 11,410,159	$ (17,829,005)	$ 142,126,358

Construction in progress at June 30, 2015 consists of various projects for additions and renovations to the Primary Health System's facilities. The estimated cost to complete construction projects is approximately $85,000,000.

During 2012, the Primary Health System entered into an agreement to sell certain professional office buildings (POBs) and concurrently entered into agreements to lease space from the purchaser. The sales price of the POBs was approximately $13,333,000, and a gain of approximately $6,695,000 was realized. Since the Primary Health System is leasing back certain space, a portion of the gain has been deferred and is being recognized over the terms of the leases. Amortization of the deferred gain is included in non-operating revenue (expenses) for the year ended June 30, 2015. The leases entered into (or committed to) under this sale/leaseback agreement include certain leases which meet the criteria for capitalization and are included in Note M.

NOTE F--INVESTMENTS AND ASSETS LIMITED AS TO USE

The Primary Health System invests in United States government and agency bonds, municipal bonds, corporate debt, certificates of deposit and short-term money market investments that are in accordance with the Primary Health System's investment policy. Temporary investments at June 30, 2015 consist primarily of cash equivalents, government bonds and commercial paper.

The carrying and estimated fair values for long-term investments, and assets limited as to use, by type, at June 30, 2015 are as follows:

	Primary Health System
U.S. Government and agency bonds, including municipal bonds, mutual funds, and other	$ 132,355,866
Corporate bonds and commercial paper	41,572,069
Short-term investments and cash equivalents	12,916,366
Total investments and assets limited as to use	$ 186,844,301

Assets limited as to use are designated for the following purposes:

	Primary Health System
Capital investment funds	$ 102,544,397
Under bond indentures - held by trustees	76,706,179
Self-insurance trust	5,645,447
Health plan trust	1,623,416
	$ 186,519,439

Assets limited as to use for capital improvements are to be used for the replacement of property and equipment or for any other purposes so designated.

Funds held by trustees under bond indenture at June 30 are as follows:

	Primary Health System
Debt service reserve funds	$ 6,195,383
Construction fund	70,510,796
Total funds held by trustees under bond indenture	$ 76,706,179

The debt service reserve fund is to be used only to make up any deficiencies in other funds related to the Hospital Revenue and Refunding Bonds Series 2004. The construction fund may be used for various construction and renovation projects related to the Series 2014 bonds.

The Primary Health System's investment policy specifies the types of investments which can be included in board-designated assets limited as to use, as well as collateral or other security requirements. The investment policy also specifies the maximum maturity of the portfolio of board-designated assets. Assets limited as to use and held by trustees are invested as permitted by the bond indenture.

Custodial Credit Risk: The Primary Health System's investment securities are exposed to custodial credit risk if the securities are uninsured, are not registered in the name of the Primary Health System, and are held by either the counterparty or the counterparty's trust department or agent but not in the Primary Health System's name. The risk is that, in the event of the failure of the counterparty to a transaction, the Primary Health System will not be able to recover the value of the investment or collateral securities that are in the possession of an outside party.

As of June 30, 2015, the Primary Health System's investments, including assets limited as to use, were comprised of various short-term investments, U.S. government and government agency bonds, municipal obligations, corporate bonds, commercial paper, and other U.S. Treasury obligations. Substantially all of the Primary Health System's investments, including assets limited as to use, are uninsured or unregistered. Securities are held by the counterparty, or by its trust department or agent, in the Primary Health System's name.

Concentration of Credit Risk: This is the risk associated with the amount of investments the Primary Health System has with any one issuer that exceeds 5% or more of its total investments. Investments issued or explicitly guaranteed by the U.S. Government and investments in mutual funds, external investment pools, and other pooled investments are excluded from this requirement. The Primary Health System's investment policy does not restrict the amount that may be held for any single issuer. At June 30, 2015, none of the Primary Health System's investments with any one issuer exceed 5% of its total investments except certain U.S. Government agencies.

Credit Risk: This is the risk that an issuer or other counterparty to an investment will not fulfill its obligations. GASB No. 40 requires that disclosure be made as to the credit rating of all debt security investments except for obligations of the U.S. Government or obligations explicitly guaranteed by the U.S. Government. The Primary Health System's investment policy provides guidelines for its fund managers and lists specific allowable investments.

The credit risk profile of the Primary Health System's investments, including assets limited as to use (excluding U.S. Government securities), as of June 30, 2015, is as follows:

Investment Type	*Balance as of June 30, 2015*	*Rating*				
		AAA	*AA*	*A*	*BBB*	*N/A*
U.S Government agency bonds	$ 63,486,611	$ 61,980,956	$ 1,505,655	$ -	$ -	$ -
Municipal bonds	21,187,282	12,730,094	6,746,950	1,710,238	-	-
Bond mutual funds	5,593,772	5,593,772	-	-	-	-
Corporate bonds and commercial paper	36,093,132	-	-	36,093,132	-	-
Cash equivalents	12,745,231	-	-	-	-	12,745,231
Total investments	$ 139,106,028	$ 80,304,822	$ 8,252,605	$ 37,803,370	$ -	$ 12,745,231

Interest Rate Risk: This is the risk that changes in interest rates will adversely affect the fair value of an investment. The Primary Health System's investment policy authorizes a strategic asset allocation that is designed to provide an optimal return over the Primary Health System's investment horizon and within specified risk tolerance and cash requirements.

The distribution of the Primary Health System's investments, including assets limited as to use, by maturity as of June 30, 2015, is as follows:

Investment Type	*Balance as of June 30, 2015*	*Remaining Maturity*				
		12 months or less	*13-24 Months*	*25-60 Months*	*Over 60 Months*	*N/A*
U.S. Government bonds and agency funds	$ 111,224,887	$ 40,933,561	$ 26,492,971	$ 15,186,259	$ 28,612,096	$ -
Municipal bonds	21,187,282	11,629,322	3,065,355	6,492,605	-	-
Bond mutual funds	5,593,772					5,593,772
Corporate bonds and commercial paper	36,093,132	36,093,132	-	-	-	-
Cash equivalents	12,745,228	12,745,228	-	-	-	-
Total investments	$ 186,844,301	$ 101,401,243	$ 29,558,326	$ 21,678,864	$ 28,612,096	$ 5,593,772

NOTE G--LONG-TERM DEBT

Long-term debt at June 30, 2015 consists of the following:

	Primary Health System
Revenue and Refunding Bonds, Series 2014A, including bond premium of $8,511,142	$ 158,431,142
Revenue and Refunding Bonds, Series 2004, net of bond discount of $374,681 and including bond issue premium of $719,347	40,429,666
Total bonds payable	198,860,808
2014B Note payable	12,000,000
Other loans	644,748
Capital leases - Note M	6,379,361
	217,884,917
Less: current portion	(4,782,194)
	$ 213,102,723

On December 1, 2014, the Primary Health System issued $149,920,000 Series 2014A bonds for the purpose of advance refunding $20,615,000 of the outstanding Series 2004 bonds (described below), $30,300,000 of the outstanding Series 2000 bonds, $17,375,000 of the Series 1998A bonds, and $27,465,000 of the outstanding Series 1997A bonds. The Primary Health System also utilized the proceeds to pay certain issuance costs and deposited a portion of the bond proceeds in the amount of $71,000,000 into a construction fund. The advance refunding of the of the Series 2004 bonds, Series 1998A bonds, and 1997A bonds resulted in a loss of $1,116,755 that is reported as a deferred outflow of resources and will be amortized over the term of the Series 2014A bonds.

The Series 2014A bonds consist of series bonds maturing annually beginning October 1, 2016 through 2034 and term bonds maturing on October 1, 2039 and 2044. The term bonds are subject to mandatory sinking fund redemption beginning October 1, 2035. The Series 2014A bonds are also subject to redemption by the Primary Health System at any interest payment date at a redemption price equal to the principal amount plus accrued interest.

Interest rates for the Series 2014A bonds are as follows:

Series bonds	- 3.0% to 5.0%
Term bonds	- 4.125% to 5.0%

In conjunction with the issuance of the Series 2014A bonds, the Primary Health Systems issued a $12,000,000 note payable (2014B note) through a financial institution to advance refund the remaining $11,775,000 of outstanding Series 1997A bonds and pay issuance costs. Principal payments of $100,000 are due annually beginning October 1, 2018 until the maturity date of October 1, 2021. The 2014B note bears interest, payable monthly, at a variable rate equal to the 1-month London Interbank Offered Rate plus a margin ranging from .73% to 2.25% based on the debt rating of the Primary Health System. The applicable interest rate at June 30, 2015 was 1.174%.

On January 1, 2004, the Primary Health System issued $85,000,000 insured Series 2004 bonds for the purpose of refunding $80,925,000 of the total outstanding Series 1993 bonds. The Primary Health System also utilized the proceeds to pay certain issuance costs and establish a debt service fund. The outstanding Series 2004 bonds mature annually on October 1 through 2022 in varying amounts. The Series 2004 bonds maturing after October 1, 2019 may be redeemed by the Primary Health System after October 1, 2019 at a redemption price equal to the principal amount plus accrued interest. Interest rates for the outstanding Series 2004 bonds range from 4.0% to 5.0%.

During 2015, a portion of the Series 2004 bonds totaling $20,615,000 were defeased with the issuance of the Series 2014A bonds proceeds through the deposit of funds into an irrevocable escrow account in amounts sufficient to pay the principal and interest when due. A portion of the defeased Series 2004 bonds totaling $8,135,000 has been redeemed. The escrow balance for payment of the remaining principal and interest totaled $13,903,430 at June 30, 2015.

The Series 2014A bonds, Series 2004 bonds and 2014B note were issued on parity, with respect to collateral, and are also secured by a mortgage on a portion of the Primary Health System's main campus. The trust indentures and related documents underlying the bonds contain certain covenants and restrictions. As of June 30, 2015, management believes the Primary Health System is in compliance with all such covenants.

In August 2000, the Primary Health System issued $47,300,000 insured Series 2000 bonds for the purpose of refunding $40,000,000 of the outstanding Series 1987 bonds and funding a debt service reserve fund and to pay issuance costs. The outstanding Series 2000 bonds were redeemed with the proceeds of the Series 2014A bonds during 2015.

The Primary Health System's 1997A and 1998A Hospital Revenue Bonds were issued to fund capital improvements for Erlanger Medical Center and establish a debt service reserve fund (1998A only). The outstanding Series 1997A and Series 1998A bonds were redeemed with the proceeds of the Series 2014A bonds and 2014B note during 2015.

Year Ended June 30, 2015

Long-term debt activity for the Primary Health System for the year ended June 30, 2015 consisted of the following:

	Balance at June 30, 2014	*Additions/ Amortizations*	*Reductions/ Accretions*	*Balance at June 30, 2015*
Bonds Payable				
Series 2014	$ -	$ 158,600,880	$ 169,738	$ 158,431,142
Series 2004	66,859,457	68,518	26,498,309	40,429,666
Series 2000	32,558,296	-	32,558,296	-
Series 1998A	18,159,154	265,846	18,425,000	-
Series 1997A	41,000,000	-	41,000,000	-
Total bonds payable	158,576,907	158,935,244	118,651,343	198,860,808
2014B Note payable	-	12,000,000	-	12,000,000
Other loans	4,978,158	865,000	5,198,410	644,748
Capital leases	6,575,290	-	195,929	6,379,361
Total long-term debt	$ 170,130,355	$ 171,800,244	$ 124,045,682	$ 217,884,917

The Primary Health System's scheduled principal and interest payments (estimated for variable rate debt based on rates at June 30, 2015) on bonds payable and other long-term debt (excluding capital leases) are as follows for the years ending June 30:

Year Ending June 30,	*Principal*	*Interest*	*Total*
2016	$ 4,701,350	$ 9,265,265	$ 13,966,615
2017	4,643,398	9,048,385	13,691,783
2018	4,575,000	8,854,983	13,429,983
2019	5,060,000	8,635,334	13,695,334
2020	5,295,000	8,395,029	13,690,029
2021-2025	26,425,000	38,156,610	64,581,610
2026-2030	25,850,000	33,545,955	59,395,955
2031-2035	32,675,000	26,695,969	59,370,969
2036-2040	41,330,000	17,907,853	59,237,853
2041-2045	52,095,000	6,765,875	58,860,875
TOTAL	$ 202,649,748	$ 167,271,258	$ 369,921,006

NOTE H--PENSION PLAN

Plan Description: The Primary Health System sponsors the Chattanooga-Hamilton County Hospital Authority Pension Retirement Plan & Trust (the Plan), a single-employer, non-contributory defined benefit pension plan covering employees meeting certain age and service requirements.

The Primary Health System has the right to amend, in whole or in part, any or all of the provisions of the plan. Effective July 1, 2009, the plan was amended to be closed to new employees or rehires, and to further clarify the maximum years of service to be 30. During June 2014, the plan was amended to freeze the accrual of additional benefits.

Benefits Provided: In addition to normal retirement benefits, the Plan also provides for early retirement, disability and death benefits. Retirement benefits are calculated as a percent of the employee's average monthly salary for the last 10 calendar years times the employee's years of service. Employees earn full retirement benefits after 30 years of service. Early retirement benefits are available once an employee has reached age 55 and 10 years of service at a reduced rate based on age. Disability retirement benefits are available after 3 years of credited service, determined in the same manner as retirement benefits and are payable at the normal retirement date. Death benefits equal the actuarial equivalent value of the employee's vested accrued benefit as of the date of death. An employee who terminates service for other reasons after three years of credited service will receive retirement benefits at the normal retirement date

Employees Covered: At January 1, 2015, the following employees were included in the Plan:

Active employees	2,103
Inactive employees with deferred benefits	1,364
Inactive employees currently receiving benefits	179
	3,646

Contributions: The Primary Health System funds the plan as contributions are approved by the Board of Trustees based on an actuarially determine rate recommended by an independent actuary. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned during the year with an additional amount to finance any unfunded accrued liability.

Net Pension Liability: The Primary Health System's net pension liability was measured as of June 30 2015, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of January 1, 2015. The total pension liability in the

actuarial valuation was determined using the following actuarial assumptions, applied to all periods included in the measurement:

Inflation	2.5%
Salary increases	N/A
Investment rate of return	7.5%
Discount rate	7.5%

Mortality rates were based on the RP-2014 Mortality for Employees, Healthy Annuitants, and Disabled Annuitants, with generational projection per MP-2014.

The long-term expected rate of return on pension plan investments was determined using a method in which best-estimate ranges of expected future real rates of return (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class. The target allocation and best estimates of arithmetic real rates of return for each major asset class are summarized as follows:

Asset Class	*Target Allocation*	*Long-term Expected Real Rate of Return*
Fixed income	10.00%	1.54%
Short-term bonds	5.00%	1.08%
Domestic equities	25.00%	5.71%
Global equities	17.50%	5.76%
Foreign equities	20.00%	6.01%
Real estate	5.00%	5.19%
Hedge funds	17.50%	5.50%

The pension plan's fiduciary net position was projected to be available to make all projected future benefit payments of current active and inactive employees assuming the actuarially determine contributions are made each year, although not required by the funding policy. Therefore, the discount rate for determining the total pension liability is equal to the long-term expected rate of return on pension plan investments.

Changes in the Net Pension Liability:

Changes in the Primary Health System's net pension liability are as follows for the year ended June 30, 2015:

	Total Pension Liability	*Plan Fiduciary Net Position*	*Net Pension Liability*
Balance, June 30, 2014	$ 130,245,072	$ 85,753,713	$ 44,491,359
Interest	9,278,335	-	9,278,335
Liability gains or losses	(386,473)	-	(386,473)
Assumptions changes	2,284,765	-	2,284,765
Benefit payments	(13,308,452)	(13,308,452)	-
Administrative expenses	-	(515,072)	515,072
Investment income	-	5,922,518	(5,922,518)
Investment gains or losses	-	(2,596,923)	2,596,923
Employer contributions	-	1,000,000	(1,000,000)
Balance, June 30, 2013	$ 128,113,247	$ 76,255,784	$ 51,857,463

The following presents the net pension liability of the Primary Health System calculated using the current discount rate of 7.5 percent, as well as what the net pension liability would be if it were calculated using a discount rate that is 1-percentage-point lower (6.5%) or 1-percentage-point higher (8.5%) than the current rate:

	1% Decrease 6.5%	*Current Rate 7.5%*	*1% Increase 8.5%*
Total pension liability	$ 137,256,238	$ 128,113,247	$ 120,128,551
Fiduciary net position	76,255,784	76,255,784	76,255,784
Net pension liability	61,000,454	51,857,463	43,872,767

Pension Expense and Deferred Outflows and Deferred Inflows of Resources: For the year ended June 30, 2015, the Primary Health System recognized pension expense totaling $4,725,070. At June 30, 2015, the Primary Health System reported deferred outflows of resources and deferred inflows of resources from the following sources:

	Deferred Outflows of Resources	*Deferred Inflows of Resources*
Differences between expected and actual experience	$ -	$ 318,312
Changes of assumptions	1,881,808	-
Differences between projected and actual earnings	2,077,533	-
	$ 3,959,341	$ 318,312

Amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized in pension expense as follows:

Year Ending June 30,		
2016	$	854,181
2017		854,181
2018		854,181
2019		854,181
2020		224,312

NOTE I--OTHER RETIREMENT PLANS

The Primary Health System maintains defined contribution plans under Section 403(b) and 401(a) of the IRC which provides for voluntary contributions by employees. The Plans are for the benefit of all employees 25 years of age or older with at least 12 months of employment.

The Primary Health System matches 50% of each participant's contribution up to 2% of the participant's earnings. For eligible employees hired on or after July 1, 2009, the Primary Health System will make profit sharing contributions equal to 3% of their earnings, regardless if the employee is making contributions. Additionally, active employees in the frozen pension plan will receive an additional 2.5% contribution through fiscal year 2019. Employer and employee contributions to the plans were approximately $1,740,000 and $7,500,000, respectively for the year ended June 30, 2015.

NOTE J--POST-EMPLOYMENT BENEFITS OTHER THAN PENSIONS

The Primary Health System sponsored three post-employment benefit plans other than pensions (OPEB) for full-time employees who had reached retirement age, as defined. The respective plans provided medical, dental, prescription drug and life insurance benefits, along with a limited lump-sum cash payment for a percent of the hours in the participant's short-term disability at retirement. The postretirement health, dental and prescription drug plan was contributory and contained other cost-sharing features, such as deductibles and coinsurance. The life insurance plan and the short-term disability were noncontributory.

During 2014, the postretirement health, dental and prescription drug plan were amended to increase the amount of required participant contributions. Additionally, eligibility for the short-term disability was limited to employees that had attained age 55 and completed 10 years of service as of January 1, 2014 or attained age 65 with at least 5 years of service as of this date. The lump-sum payout for the short-term disability was also reduced from 50% to 20% of the amount accumulated. During 2015, all post-employment benefit plans were terminated and no

further benefits will be paid. The termination of these plans reduced other long-term liabilities by approximately $3,650,000 and is reported as a reduction of operating expenses in the combined financial statements.

NOTE K--MEDICAL MALPRACTICE AND GENERAL LIABILITY CLAIMS

As of January 1, 1976, the Primary Health System adopted a self-insurance plan to provide for malpractice and general liability claims and expenses arising from services rendered subsequent to that date. In 1980, the Primary Health System's Self-Insurance Trust Agreement (the Agreement) was amended to include all coverages that a general public liability insurance policy would cover. In 1988, the Agreement was amended and restated to comply with amendments to the Tennessee Governmental Tort Liability Act and to formally include any claims and expenses related to acts of employees of the Primary Health System. The Primary Health System is funding actuarial estimated liabilities through a revocable trust fund with a bank. The trust assets are included as a part of assets limited as to use in the accompanying combined statements of net position. Such amounts in the trust can be withdrawn by the Primary Health System only to the extent there is an actuarially determined excess. The annual deposit to the self-insurance trust fund is determined by management based on known and threatened claims, consultation with legal counsel, and a report of an independent actuary. Losses against the Primary Health System are generally limited by the Tennessee Governmental Tort Liability Act to $300,000 for injury or death to any one person in any one occurrence or $700,000 in the aggregate. However, claims against healthcare practitioners are not subject to the foregoing limits applicable to the Primary Health System. Any such individuals employed by the Primary Health System, excluding employed physicians for which the Primary Health System has purchased insurance coverage, are covered by the Trust to the limits set forth therein.

In the opinion of management, the revocable trust fund assets are adequate at June 30, 2015 to cover potential liability and malpractice claims and expenses that may have been incurred to that date.

The Primary Health System provides for claims and expenses in the period in which the incidence related to such claims occur based on historical experience and consultation with legal counsel. It is the opinion of management that the reserve for estimated losses and loss adjustment expense (LAE) at June 30, 2015 is adequate to cover potential liability and malpractice claims which may have been incurred but not reported (IBNR) to the Primary Health System. Such reserve for IBNR claims reflects a discount rate of 5.5% based on the Primary Health System's expected investment return during the payout period.

NOTE L--COMMITMENTS AND CONTINGENCIES

Litigation: The Primary Health System is subject to claims and suits which arise in the ordinary course of business. In the opinion of management, the ultimate resolution of such pending legal proceedings has been adequately provided for in its combined financial statements, and will not have a material effect on the Primary Health System's results of operations or financial position.

The prior Chief Executive Officer (CEO) resigned from the Primary Health system on December 31, 2011, after an interim CEO (the Executive Vice President) was established December 1, 2011. The interim CEO was replaced by the current CEO, hired on April 1, 2013. The Executive Vice President's employment ended when her leave expired in June, 2013. She has filed a wrongful termination lawsuit against the Primary Health System for $25 million, which the Primary Health System, in conjunction with its Directors and Officers insurance carrier, is currently defending. Management believes that insurance coverage is adequate to cover any settlement. The ultimate outcome of this lawsuit is uncertain and, therefore, no estimate of loss has been recorded in the combined financial statements.

Workers Compensation: The Primary Health System has a job injury program to provide benefits to workers injured in employment-related accidents. This program provides medical and indemnity benefits to employees injured in the course of employment for a period up to 24 months from the date of injury. The Primary Health System has recorded a projected liability that is included in other long-term liabilities in the combined statements of net position. The projected liability was discounted using a 4% rate of return at June 30, 2015.

Healthcare Benefits: The Primary Health System maintains a self-insured healthcare plan to provide reimbursement for healthcare expenses for covered employees. The Primary Health System has estimated and recorded a liability for claims incurred but not reported in the combined financial statements.

Regulatory Compliance: The healthcare industry is subject to numerous law and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, Medicare fraud and abuse, and most recently under the Provision of Health Insurance Portability and Accountability Act of 1996, matters related to patient records, privacy and security. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers, such as the Medicare Recovery Audit Contractor Program. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Compliance with such

laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

In the normal course of business, the Primary Health System continuously monitors and investigates potential issues through its compliance program. Management believes that the Primary Health System is in compliance with applicable laws and regulations or has reported any amounts payable related to known violations, including amounts identified through the Medicare Recovery Audit Contractor program, or similar initiatives, and any settlements will not have a significant impact on the combined financial statements. However, due to the uncertainties involved and the status of ongoing investigations, management's estimate could change in the near future and the amount of the change could be significant.

Health Care Reform: In March 2010, Congress adopted comprehensive healthcare insurance legislation, Patient Care Protection and Affordable Care Act and Health Care and Education Reconciliation Act. The legislation, among other matters, is designated to expand access to coverage to substantively all citizens through a combination of public program expansion and private industry health insurance. Changes to existing TennCare and Medicaid coverage and payments are also expected to occur as a result of this legislation. Implementing regulations are generally required for these legislative acts, which are to be adopted over a period of years and, accordingly, the specific impact of any future regulations is not determinable.

NOTE M--LEASES

Capital: As discussed in Note E, during 2012, the Primary Health System entered into a sale/leaseback arrangement, under which certain leases of office space meet the criteria as capital leases. Interest on these leases has been estimated at 7% per annum.

During 2011, the Primary Health System acquired a parcel of land from the Industrial Development Board of the City of Chattanooga, Tennessee for a nominal amount. The Primary Health System also entered into a project development agreement with a developer to facilitate final design, financing and construction of a medical office building for the benefit of Volkswagen Group of America Chattanooga Operations, LLC (Volkswagen) on this land. The Primary Health System has entered into a forty-year ground lease, with the option of two ten-year renewal terms, of the parcel to the developer. Additionally, in 2012, the Primary Health System has entered into a twenty year lease with the developer for certain space in the medical office building for a wellness center and other operations under a capital lease agreement.

The following is a summary of the property under capital leases by major classes at June 30, 2015:

	Primary Health System
Buildings	$ 6,599,976
Equipment	494,905
	7,094,881
Less: accumulated amortization	(1,762,056)
	$ 5,332,825

The following is a schedule of future minimum lease payments under capital leases:

Year Ending June 30,	
2016	$ 733,585
2017	729,999
2018	744,453
2019	759,311
2020	774,587
2021-2025	3,728,737
2026-2030	4,137,530
2031-2033	1,041,823
Total minimum lease payments	12,650,025
Less: amount representing interest	(6,270,664)
Present value of minimum lease payments	$ 6,379,361

Operating: The Primary Health System rents office space and office equipment under non-cancelable operating leases through 2033, containing various lease terms. The leases have other various provisions, including sharing of certain executory costs. Rent expense under operating leases was approximately $9,810,000 in 2015.

Future minimum lease commitments for all non-cancelable leases with terms in excess of one year are as follows:

Year Ending June 30,	
2016	$ 6,231,365
2017	4,242,932
2018	3,765,250
2019	3,573,659
2020	3,020,973
Thereafter	18,879,687
	$ 39,713,866

Rental Revenues: The Primary Health System leases office space to physicians and others under various lease agreements with terms in excess of one year. Rental revenue recognized for the years ended June 30, 2015 totaled approximately $3,016,000. The following is a schedule of future minimum lease payments to be received:

Year Ending June 30,	
2016	$ 2,131,770
2017	943,730
2018	740,605
2019	532,025
2020	503,251
Thereafter	493,686
	$ 5,345,067

NOTE N--DERIVATIVE FINANCIAL INSTRUMENTS

Simultaneous with the issuance of the $85,000,000 Series 2004 bonds discussed in Note G, the Primary Health System entered into two distinct interest rate swap agreements with a third party (described below) in an effort to take advantage of the differences between taxable and tax-exempt debt. The interest rate swap agreements were terminated during 2015.

With respect to the 1997A Series bonds, the Primary Health System executed a swap agreement whereby the Primary Health System received a variable rate equal to the one-month LIBOR-BBA rate and paid a fixed rate equal to 5.087% on a notional amount of $41,000,000.

With respect to the 1998A Series bonds, the Primary Health System executed a swap agreement whereby the Primary Health System received a fixed rate of 3.932% and pays a variable rate

equal to the Securities Industry and Financial Markets Association (SIFMA) Municipal Swap Index on a notional amount of $16,305,000.

Although these swap instruments were intended to manage exposure to interest rate risks associated with the various debt instruments referred to above, none of these swap agreements were determined to be effective hedges. Accordingly, the changes in the value of the swaps are reflected as a component of non-operating revenues in the combined statements of revenue, expenses and changes in net position. The termination of the swap agreements resulted in a payment of approximately $3,200,000 and a reduction of other long-term liabilities.

NOTE O--MANAGEMENT AGREEMENT

On April 13, 2011, the Primary Health System's Board of Trustees approved a resolution authorizing a management agreement (the Agreement) between the Primary Health System, Hutcheson Medical Center, Inc. and affiliates (collectively, Hutcheson) and the Hospital Authority of Walker, Dade and Catoosa Counties in Georgia (the Hospital Authority).

Under the terms of the Agreement, the Primary Health System proposed general operating policies and directives for Hutcheson; was responsible for the day-to-day management of Hutcheson and provided oversight of ancillary aspects of Hutcheson, such as physician practices, education, research, and clinical services. The Agreement's initial term was to be through March 31, 2021 with the Primary Health System to have the option to extend the agreement for two additional five year terms. The Primary Health System was authorized to terminate the Agreement, without cause, upon written notice at any point subsequent to May 25, 2013. Upon such termination, Hutcheson was to be obligated to make a Termination Payment to the Primary Health System consisting of all expenses then owed by Hutcheson and any outstanding advances under a Line of Credit Agreement, discussed below. Hutcheson could also terminate the agreement without cause at any point subsequent to May 25, 2013 by paying the Termination Payment, as well as the lesser of a) $1,000,000 per year for each year the Agreement has been in place, or b) $1,000,000 less any management fees paid in each Agreement year.

In addition to the Agreement, the Primary Health System agreed to extend a Line of Credit (the Line) to the Hospital Authority. The maximum amount available under the Line was $20,000,000 and at June 30, 2015, the draws on the Line totaled $20,000,000.

The Line called for interest only payments each month on the outstanding balance, based on the London InterBank Offered Rate plus 4% or a rate of 5%, whichever is greater. However, any unpaid interest through March 31, 2013 was deferred and to be paid over a twelve-month period commencing on that date. All outstanding draws were due at the maturity date, which is consistent with the Agreement termination dates, discussed above.

The Line is secured by a Security Agreement on the primary Hutcheson medical campus. Further, the Counties of Walker and Catoosa, Georgia (collectively, the Counties) have provided additional security in the form of guarantees under an Intergovernmental Agreement. Under the Intergovernmental Agreement, the Counties have each agreed to a maximum liability of $10,000,000 to secure the line. The form of such guarantee was to be at the option of the Counties and were to become enforceable upon a notice of default delivered by the Primary Health System. The form of the guarantee selected by the Counties can include a) a payment of 50% by each County of the amounts owing under the Line, b) payments as they become due up to the respective $10,000,000 limits or c) after non-Judicial foreclosure under the Security Agreement, each County could elect to pay 50% of any deficiency between the amount outstanding under the Line and the then fair market value. Both Counties previously agreed to levy annual property taxes, if needed to honor these guarantees.

In June 2013, the Agreement was modified to allow Hutcheson to issue requests for proposals for the lease or sale of Hutcheson properties without creating a breach of the Agreement. As part of the Agreement, Hutcheson committed to obtain alternative financing and repay the line of credit upon the earlier of the replacement financing being obtained by Hutcheson, or June 1, 2014.
In August of 2013, however, Hutcheson terminated the Agreement. In response thereto, the Primary Health System declared Hutcheson to be in default under the Agreement and made formal demand of Hutcheson as to all amounts then due and payable. In February 2014, the Primary Health System filed suit against Hutcheson in order to collect the moneys, including principal, interest and penalties, then due. In response to such filing, Hutcheson has asserted multiple counter claims against the Primary Health System alleging mismanagement and other failures under the Agreement. Additionally, another senior creditor has filed a separate lawsuit against the Primary Health System alleging priority over the Primary Health System's security interest and, presumably, the County guarantees relating to Hutcheson. The litigation is currently pending in the United States District Court in the Northern District of Georgia, Rome Division.

During the pendency of the litigation, Hutcheson's operating entities (Hutcheson Medical Center, Inc. and Hutcheson Medical Division, Inc., but not the Hospital Authority) filed for Chapter 11 bankruptcy protection in the Northern District of Georgia. Such filing automatically stayed the pending litigation to the extent it pertains to Hutcheson's operating entities. As of the date of this Note, the Hutcheson entities, remains in Chapter 11 still with no plan of reorganization. On September 15, 2015, the Bankruptcy Court appointed a Chapter 11 Trustee in order to facilitate a sale of Hutcheson's interests. The Primary Health System remains actively involved in the bankruptcy action to ensure that its interests remain adequately protected.

Regions Bank (Regions) is also a creditor of Hutcheson and initiated related litigation in the U.S. District Court for the Northern District of Georgia in Rome (Case No. 4:14-cv-00191) against the Primary Health System in its effort to protect its interest, if any, in the litigation. Specifically, Regions claims the Primary Health System's interest is subordinate to its interest and seeks a declaration of such priority. Regions claims that Hutcheson owes Regions in excess of $22.3 million that is allegedly a senior debt to the debt Hutcheson owes to the Primary Health System. Regions further claims that the Primary Health System's attempted foreclosure constitutes a breach of the Management Agreement to which Regions is allegedly a third party beneficiary and related contracts. Regions filed a Motion for a temporary restraining order on July 28, 2014, seeking to enjoin the foreclosure proceedings. The Court denied Regions Motion for a temporary restraining order as moot in light of the injunctive relief it granted to Hutcheson in the related litigation. Regions filed a second Motion for a temporary restraining order on October 15, 2014, which was heard on October 24, 2014. The Court again denied the Motion for a temporary restraining order as moot due to the injunctive relief granted to Hutcheson in the related litigation. The Primary Health System filed a Motion to Dismiss in the Regions suit, which was granted on October 29, 2014 and dismissed all claims against the Primary Health System in their entirety. Regions appealed the dismissal to the 11th Circuit. To date, that court has yet to rule on the appeal.

NOTE P--OTHER REVENUE

The American Recovery and Reinvestment Act of 2009 and the Health Information Technology for Economic and Clinical Health (HITECH) Act established incentive payments under the Medicare and Medicaid programs for certain healthcare providers that use certified Electronic Health Record (EHR) technology. To qualify for incentive payments, healthcare providers must meet designated EHR meaningful use criteria as defined by the Centers for Medicare & Medicaid Services (CMS). Incentive payments are awarded to healthcare providers who have attested to CMS that applicable meaningful use criteria have been met. Compliance with meaningful use criteria is subject to audit by the federal government or its designee and incentive payments are subject to adjustment in a future period. The Primary Health System recognizes revenue for EHR incentive payments when substantially all contingencies have been met. During 2015, the Primary Health System recognized approximately $1,456,000 of other revenue related to EHR incentive payments.

NOTE Q--CONDENSED FINANCIAL INFORMATION

The following is condensed, financial information related to the discretely presented component units as of and for the year ended June 30, 2015:

	ContinuCare	*Cyberknife*
Due from other governments	$ 289,425	$ 120,400
Other current assets	10,998,935	615,455
Total Current Assets	11,288,360	735,855
Net property, plant and equipment	4,767,830	3,691,914
Other assets	500,663	56,482
Total Assets	$ 16,556,853	$ 4,484,251
Due to other governments	$ 130,037	$ -
Other current liabilities	2,623,920	3,051,492
Total Current Liabilities	2,753,957	3,051,492
Long-term debt and capital lease obligations	25,035	85,186
Total Liabilities	2,778,992	3,136,678
Net position		
Unrestricted	9,064,490	691,234
Net investment in capital assets	4,713,371	656,339
Total Net Position	13,777,861	1,347,573
Total Liabilities and Net Position	$ 16,556,853	$ 4,484,251
Net patient and operating revenue	$ 27,536,041	$ 1,935,000
Operating expenses:		
Salaries, wages and benefits	13,841,457	222,148
Supplies and other expenses	12,705,142	663,305
Depreciation	522,014	626,840
Total Operating Expenses	27,068,613	1,512,293
Operating Income	467,428	422,707
Nonoperating expenses	(253,723)	(148,025)
Change in Net Position	213,705	274,682
Net Position at Beginning of Period	13,564,156	1,072,891
Net Position at End of Period	$ 13,777,861	$ 1,347,573

ContinuCare owes the Primary Health System for various services, supplies, and rents provided, or expenses paid on its behalf. Actual expenses incurred related to these services were $2,022,540 in 2015. In addition, ContinuCare provides staffing, contract nurse visits, and administrative services to the Primary Health System. Revenues from such services were $538,569 for the year ended June 30, 2015. Amounts due at June 30, 2015 are included in amounts due to/from other governments in the accompanying combined financial statements. As of June 30, 2015, Cyberknife owes the Primary Health System for various services, supplies and

rents provided, or expenses paid on its behalf. The Primary Health System owes Cyberknife for radiation services provided by Cyberknife to the Primary Health System's patients. Revenues related to those services provided to the Primary Health System were $1,935,000 in 2015. Amounts due at June 30, 2015 are included in amounts due to/from other governments in the accompanying combined financial statements.

Required Supplementary Information

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Schedule of Changes in Net Pension Liability and Related Ratios

Year Ended June 30, 2015

Total pension liability	
Interest	$ 9,278,335
experience	(386,473)
Changes of assumptions or inputs	2,284,765
Benefit payments	(13,308,452)
Net change in total pension liability	(2,131,825)
Total pension liability, beginning of year	130,245,072
Total pension liability, end of year	$ 128,113,247
Plan fiduciary net position	
Contributions - employer	$ 1,000,000
Net investment income, net	3,325,595
Benefit payments	(13,308,452)
Administrative expense	(515,072)
Net change in plan fiduciary net position	(9,497,929)
Plan fiduciary net position, beginningof year	85,753,713
Plan fiduciary net position, end of year	$ 76,255,784
Net pension liability, end of year	$ 51,857,463
Fiduciary net position as a percentage of the total pension liability	59.52%
Covered-employee payroll	$ 117,027,000
Net pension liability as a percentage of covered-employee payroll	44.31%

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Schedule of Actuarial Contributions

Year Ended June 30, 2015

	2015	2014	2013	2012	2011	2010	2009	2008	2007	2006
Actuarially determine contributions	$ 4,364,255	$ 12,832,292	$ 11,165,101	$ 10,367,973	$ 8,833,977	$ 7,501,004	$ 7,192,948	$ 6,731,386	$ 8,261,320	$ 7,717,419
Actual employer contributions	1,000,000	-	11,165,101	10,367,970	8,833,977	7,501,004	7,192,000	6,172,593	7,590,497	8,371,479
Contribution deficiency	$ 3,364,255	$ 12,832,292	$ -	$ 3	$ -	$ -	$ 948	$ 558,793	$ 670,823	$ (654,060)
Covered-employee payroll	$ 117,027,311	$ 121,093,695	$ 138,807,819	$ 147,947,134	$ 144,176,724	$ 139,291,860	$ 138,478,848	$ 127,662,977	$ 134,278,637	$ 137,097,040
Contributions as a percentage of covered-employee payroll	0.85%	0.00%	8.04%	7.01%	6.13%	5.39%	5.19%	4.84%	5.65%	6.11%

Notes to Schedule:

Valuation date:	Actuarially determined contribution rates are calculated as of June 30, one year prior to the end of the fiscal year in which contributions are reported.
Actuarial cost method:	Entry age
Amortization method:	Level dollar
Amortization period:	19 years
Asset valuation method:	4-year smoothed market
Inflation:	2.5%
Lump sum interest rate:	4.0% (4.5% in prior year)
Salary increases:	N/A
Investment rate of return:	7.50%
Retirement age:	Normal retirement at 65 years, early retirement at 55 years with 10 years of service
Mortality:	RP-2014 Mortality for Employees, Health Annuitiants, and Disabled Annutitants with general projection per MP-2014 in 2015 RP-2000 Mortality for Employees, Health Annuitiants, and Disabled Annutitants projected to 2018 per Scale AA in prior year

Description	Section / Item
List Of Erlanger Patient Transfer Agreements	C-III-1

MediTract

Current Patient Transfer Agreements-01072016

Department	Organization Name	Contract Number	Contract Type	Vendor Other Party	Status	Effective Date	Expiration Date	Description
7157 - Renal Transplant Donor	Erlanger Health System	2002.4290C	Patient Transfer Agreement	Sweetwater Dialysis Center	Current	06/19/2009	Evergreen	Provide Renal Transplantation and other services to Clinic patients
7158 - Renal Transplant Administration	Erlanger Health System	2002.1508C	Patient Transfer Agreement	Dialysis Clinic, Inc	Current	03/23/1998	Evergreen	DCI Patient Transfer Agreements (all facilities -- see attachments)
7158 - Renal Transplant Administration	Erlanger Health System	2002.1636C	Patient Transfer Agreement	Rhea County Medical Center	Current	09/01/1989	Evergreen	Renal Transplant Services (Transfer)
8028 - Patient Logistics	Erlanger Health System	2002.1292C	Patient Transfer Agreement	Life Care Center of Collegedale	Current	01/01/1995	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1293C	Patient Transfer Agreement	Marshall Medical Center North	Current	02/01/2000	Evergreen	Pediatric Patient Transfer
8028 - Patient Logistics	Erlanger Health System	2002.1294C	Patient Transfer Agreement	Life Care Center of Red Bank	Current	01/01/1995	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1306C	Patient Transfer Agreement	Tender Loving Care	Current	01/01/1995	Evergreen	Hospice Transfer
8028 - Patient Logistics	Erlanger Health System	2002.1317C	Patient Transfer Agreement	LaFayette Health Care	Current	01/31/1995	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1321C	Patient Transfer Agreement	Jefferson Memorial Hospital	Current	10/22/2004	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1336C	Patient Transfer Agreement	Mountain Creek Manor	Current	01/20/1995	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1337C	Patient Transfer Agreement	Murphy Medical Center	Current	04/01/2000	Evergreen	Pediatric Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1342C	Patient Transfer Agreement	Northside Hospital	Current	04/10/1992	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1363C	Patient Transfer Agreement	Renaissance Rehabilitation	Current	04/26/1990	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1372C	Patient Transfer Agreement	Rivermont Convalescent Center	Current	01/25/1995	Evergreen	Patient Transfer
8028 - Patient Logistics	Erlanger Health System	2002.1384C	Patient Transfer Agreement	The Health Center at Standifer Place	Current	06/18/2012	Evergreen	Patient Transfer

Department	Organization Name	Contract Number	Contract Type	Vendor Other Party	Status	Effective Date	Expiration Date	Description
8028 - Patient Logistics	Erlanger Health System	2002.1385C	Patient Transfer Agreement	Shepherd Hills Health Care Center	Current	01/25/1995	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1388C	Patient Transfer Agreement	Methodist Medical Center	Current	02/06/2002	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1389C	Patient Transfer Agreement	Brookewood Medical Center	Current	06/27/2012	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1390C	Patient Transfer Agreement	Continuum Care Corporation d/b/a Spring City Health Care Center	Current	02/01/1999	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1430C	Patient Transfer Agreement	Bledsoe Community Medical Center	Current	06/27/2012	Evergreen	Patient Transfer
8028 - Patient Logistics	Erlanger Health System	2002.1446C	Patient Transfer Agreement	The University of Tennessee Medical Center	Current	05/29/2002	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1461C	Patient Transfer Agreement	Erlanger Bledsoe	Current	10/01/2001	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1483C	Patient Transfer Agreement	Cookeville Regional Medical Center	Current	02/10/2010	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1498C	Patient Transfer Agreement	Scott County Hospital	Current	01/11/2001	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1499C	Patient Transfer Agreement	Wellmont Health Systems	Current	06/30/2001	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1502C	Patient Transfer Agreement	Laughlin Memorial Hospital, Inc	Current	11/23/2011	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1539C	Patient Transfer Agreement	Fort Sanders Park West Medical Center	Current	10/22/1999	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1550C	Patient Transfer Agreement	Johnson City Medical Center	Current	05/29/2002	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1576C	Patient Transfer Agreement	Life Care Center of Chattanooga	Current	01/25/1995	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1594C	Patient Transfer Agreement	St Barnabas Nursing Home	Current	01/25/1995	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1599C	Patient Transfer Agreement	North Jackson Hospital	Current	02/01/2000	Evergreen	Pediatric Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1605C	Patient Transfer Agreement	National Health Care of Rossville	Current	05/17/2012	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1606C	Patient Transfer Agreement	National Health Care of Fort Oglethorpe	Current	05/22/2012	Evergreen	Patient Transfer Agreement

Department	Organization Name	Contract Number	Contract Type	Vendor Other Party	Status	Effective Date	Expiration Date	Description
8028 - Patient Logistics	Erlanger Health System	2002.1607C	Patient Transfer Agreement	National Healthcare of Dunlap	Current	06/20/2012	06/19/2016	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1608C	Patient Transfer Agreement	National Health Care of Athens	Current	05/15/2012	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1623C	Patient Transfer Agreement	Shriners Hospitals for Children	Current	07/01/2000	Evergreen	Pediatric Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1634C	Patient Transfer Agreement	Rhea Medical Center	Current	02/06/2002	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1650C	Patient Transfer Agreement	Siskin Hospital for Physical Rehabilitation	Current	02/09/1990	Evergreen	Shared Services
8028 - Patient Logistics	Erlanger Health System	2002.1670C	Patient Transfer Agreement	Alexian Village of Chattanooga	Current	01/01/1995	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1685C	Patient Transfer Agreement	Blount Memorial Hospital	Current	02/07/2001	Evergreen	Pediatric Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1714C	Patient Transfer Agreement	Columbia Indian Path Medical Center	Current	01/13/1997	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1715C	Patient Transfer Agreement	Columbia East Ridge Hospital	Current	03/31/1998	Evergreen	Pediatric Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1716C	Patient Transfer Agreement	East Ridge Hospital	Current	10/22/1996	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1717C	Patient Transfer Agreement	NovaMed Eye and Laser Surgery, Center of Chattanooga	Current	06/27/2002	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1750C	Patient Transfer Agreement	Jamestown Regional Medical Center, f/k/a Fentress County Hospital	Current	05/14/2012	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1753C	Patient Transfer Agreement	Cartersville Medical Center, LLC d/b/a Cartersville Medical Center	Current	05/21/2012	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.1766C	Patient Transfer Agreement	Healthsouth Chattanooga Surgery Center	Current	04/13/1999	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.2377C	Patient Transfer Agreement	St Mary's Health System, Inc	Current	04/01/2003	Evergreen	Patient Transfer Agreement

Department	Organization Name	Contract Number	Contract Type	Vendor Other Party	Status	Effective Date	Expiration Date	Description
8028 - Patient Logistics	Erlanger Health System	2002.2531C	Patient Transfer Agreement	Memorial Healthcare System d/b/a Memorial Hospital and Memorial North Park Hospital	Current	02/01/2015	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.2697C	Patient Transfer Agreement	Redmond Regional Medical Center	Current	01/17/2012	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.2699C	Patient Transfer Agreement	Murray Medical Center	Current	12/05/2011	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.2700C	Patient Transfer Agreement	Medical Center of Manchester	Current	04/17/2015	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.2702C	Patient Transfer Agreement	Lincoln County Health System	Current	11/30/2011	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.2703C	Patient Transfer Agreement	Hamilton Medical Center	Current	11/22/2011	Evergreen	Patient Transfer
8028 - Patient Logistics	Erlanger Health System	2002.2704C	Patient Transfer Agreement	Fannin Regional Hospital	Current	06/18/2012	Evergreen	Patient Transfer
8028 - Patient Logistics	Erlanger Health System	2002.2706C	Patient Transfer Agreement	Cumberland Medical Center, Inc	Current	12/02/2011	Evergreen	Patient Transfer
8028 - Patient Logistics	Erlanger Health System	2002.2707C	Patient Transfer Agreement	Copper Basin Medical Center	Current	12/01/2011	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.2830C	Patient Transfer Agreement	Gordon Hospital	Current	07/01/2012	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.2854C	Patient Transfer Agreement	Chattanooga Rehabilitation Hospital	Current	07/25/2012	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.2891C	Patient Transfer Agreement	DeKalb Regional Medical Center, f/k/a Baptist DeKalb Hospital	Current	09/28/2008	09/27/2016	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.4049C	Patient Transfer Agreement	Vanderbilt University Medical Center	Current	07/01/2008	Evergreen	Burn Patient Transfer
8028 - Patient Logistics	Erlanger Health System	2002.4234C	Patient Transfer Agreement	Physicians Surgery Center of Chattanooga	Current	04/13/2015	04/12/2059	Patient Transfer
8028 - Patient Logistics	Erlanger Health System	2002.4267C	Patient Transfer Agreement	Parkridge Medical Center	Current	05/18/2012	Evergreen	Patient Transfer
8028 - Patient Logistics	Erlanger Health System	2002.4833C	Patient Transfer Agreement	Eye Surgery Center of Chattanooga	Current	10/23/2014	Evergreen	Patient Transfer

Department	Organization Name	Contract Number	Contract Type	Vendor Other Party	Status	Effective Date	Expiration Date	Description
8028 - Patient Logistics	Erlanger Health System	2002.5425C	Patient Transfer Agreement	Renaissance Surgery Center	Current	02/16/2012	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.6972C	Patient Transfer Agreement	Kidney Center of North Georgia	Current	05/18/2015	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.6973C	Patient Transfer Agreement	Kidney Center of Cleveland, LLC	Current	05/18/2015	Evergreen	Patient Transfer Agreement
8028 - Patient Logistics	Erlanger Health System	2002.6974C	Patient Transfer Agreement	Kidney Center of Missionary Ridge	Current	05/18/2015	Evergreen	Patient Transfer Agreement (Prior Agreements 2002.4023A)
8028 - Patient Logistics	Erlanger Health System	2002.6975C	Patient Transfer Agreement	Kidney Center of Highway 58	Current	05/18/2015	Evergreen	Patient Transfer Agreement (Prior Agreements 2002.4023A)
8028 - Patient Logistics	Erlanger Health System	2002.6976C	Patient Transfer Agreement	Chattanooga Kidney Center, LLC	Current	04/20/2015	Evergreen	Patient Transfer Agreement (Prior Agreements 2002.4023A)
8028 - Patient Logistics	Erlanger Health System	2002.6977C	Patient Transfer Agreement	Chattanooga Kidney Center North, LLC	Current	05/18/2015	Evergreen	Patient Transfer Agreement (Prior Agreements 2002.4023A)
8028 - Patient Logistics	Erlanger Health System	2002.707C	Patient Transfer Agreement	Kindred Hospital	Current	10/01/2001	Evergreen	Patient Transfer Agreement
8413 - Disaster Management & EOC	Erlanger Health System	2002.6387C	Patient Transfer Agreement	East Tennessee Regional Hospitals	Current	10/10/2014	Evergreen	Disaster Aid Agreement (Memorial Health Care; Parkridge Medical Center, Inc; Southern Tennessee Medical Center (Winchester & Sewanee); Copper Basin Medical Center; Star Regional Medical Center-(Athens & Etowah); Rhea Medical Center; Skyridge Medical Center)
							No. Of Contract:	**73**

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

May 2, 2016

Joseph Winick
Senior Vice President Erlanger Health Systems
975 East 3rd Street
Chattanooga, TN 37403

RE: Certificate of Need Application -- Erlanger Behavioral Health - CN1603-012
To establish an eighty-eight (88) bed mental health hospital located at an unaddressed site at the intersection of North Holtzclaw Avenue and Citico Avenue, Chattanooga, (Hamilton County), TN 37404. The estimated project cost is $25,112,600.

Dear Mr. Winick:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need. Please be advised that your application is now considered to be complete by this office.

Your application is being forwarded to Marthagem Whitlock at the Tennessee Department of Mental Health and Substance Abuse Services for Certificate of Need review by the Division of Planning, Research, & Forensics. You may be contacted by Ms. Whitlock or someone from her office for additional clarification while the application is under review by the Department. Ms. Whitlock's contact information is Marthagem.Whitlock@tn.gov or 615-532-6717.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on May 2, 2016. The first sixty (60) days of the cycle are assigned to the Department of Mental Health and Substance Abuse, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the sixty (60) day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review within the thirty (30)-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on July 27, 2016.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill/MF

Melanie M. Hill
Executive Director

cc: Marthagem Whitlock, TDMHSAS, PRF

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

MEMORANDUM

TO: Marthagem Whitlock, Assistant Commissioner
of Planning Research & Forensics
TN Department of Mental Health and Substance Abuse Services
Division of Planning, Research & Forensics
Andrew Jackson Building, 5th Floor
500 Deaderick Street
Nashville, Tennessee 37243

FROM: Melanie M. Hill
Executive Director

DATE: May 2, 2016

RE: Certificate of Need Application
Erlanger Behavioral Health - CN1603-012

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on May 2, 2016 and end on July 1, 2016.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc: Joseph Winick, Erlanger Health Systems

LETTER OF INTENT
TENNESSEE HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Chattanooga Times Free Press, which is a newspaper of general circulation in Hamilton County, Tennessee, on or before March 10, 2016, for one day.

This is to provide official notice to the Health Services & Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et. seq.*, and the Rules of the Health Services & Development Agency, that Erlanger Behavioral Health, LLC, with an ownership type of for profit, and to be managed by itself, intends to file an application for a Certificate of Need ("CON") to construct a new psychiatric hospital with a total complement of eighty-eight (88) inpatient beds, to include services for inpatients, outpatients and substance abuse. Further, we are requesting approval to transfer twelve (12) licensed Geriatric – Psychiatric beds currently at Erlanger North Hospital to the new Erlanger Behavioral Health campus. This will create a net addition of seventy-six (76) new inpatient psychiatric beds. If approved, the number of hospital beds at Erlanger North Hospital will decrease from fifty seven (57) beds to forty-five (45) beds upon completion of the project. No other health care services will be initiated or discontinued.

The facility and equipment will be located at Erlanger Behavioral Health, at a site located at the intersection of North Holtzclaw Avenue & Citico Avenue, Chattanooga, Hamilton County, Tennessee, 37404. The total project cost is estimated to be $ 25,112,600.00.

The anticipated date of filing the application is March 15, 2016.

The contact person for this project is Joseph M. Winick, Sr. Vice President, Erlanger Health System, 975 East 3rd Street, Chattanooga, Tennessee, 37403, and by phone at (423) 778-7274.

Joseph M. Winick	March 8, 2016	Joseph.Winick@erlanger.org
	Date:	E-Mail:

The Letter Of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter Of Intent must contain the following statement pursuant to T.C.A. §68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Supplemental #1
-Original-

Erlanger Behavioral Health, LLC.

CN1603-012

SUPPLEMENTAL #1
March 28, 2016
11:49 am

SUPPLEMENTAL INFORMATION

Erlanger Behavioral Health, LLC

Application To Initiate Psychiatric Services At The
Intersection Of North Holtzclaw Avenue And Citico Avenue,
In Chattanooga, Tennessee, With Establishment
Of An Eighty-Eight (88) Bed Inpatient Hospital
By The Addition Of Seventy-Six (76) Psychiatric Beds
And The Transfer Of Twelve (12) Geriatric-Psychiatric Beds
From *Erlanger North Hospital*

Application Number CN1603-012

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

SUPPLEMENTAL #2

March 28, 2016

11:49 am

Supplemental Responses To Questions Of The Tennessee Health Services & Development Agency

1.) Section A, Applicant Profile, Item 6.

Please provide documentation, e.g., copy of a deed, etc. that Medical Development Partners, LLC currently owns the property of the site for the proposed project.

The Option to Purchase Agreement is noted. However, please clarify how the applicant can secure the property site while 100% of the proposed project will be funded by an unrelated party not included in the Option to Purchase Agreement. In addition, there is no address listed on the agreement. Please revise.

Response

A *Quit Claim Deed* dated December 31, 2007, filed in the Register's Office of Hamilton County, Tennessee, on April 4, 2008, is attached to this supplemental information.

A *Letter of Agreement* between *Erlanger Health System* and *Acadia Healthcare* is attached to this supplemental information. The agreement specifies the responsibilities of each party in the joint venture and satisfactorily outlines the two (2) stage process which will be followed in development of this project, ultimately leading to *Acadia* fully funding the project.

Attached to the CON application was a copy of the *Option To Purchase Real Estate*. Along with this *Option*, a copy of the *Letter of Agreement* between *Erlanger* and the *Purchaser* of the real estate, *Hickory Land Co., LLC*, in which the *Purchaser* agrees to "irrevocably assign to *Erlanger* or to a subsidiary or an affiliate of *Erlanger* (including a joint venture) at *Erlanger's* discretion, all of Purchaser's rights, benefits, title, interests, liabilities and obligations" under the *Option To Purchase*. As such, *Erlanger* does control the site.

The *Option To Purchase* does specify an address in the first paragraph, that is 804 N. Holtzclaw Avenue. However, there are two (2) parcels stipulated in the first

paragraph, those are tax parcels 146C-A022 and 146C-A023. Since the proposed site for the new hospital straddles both parcels, it is as yet undetermined which parcel will be the actual mailing address of the facility.

2.) Section A, Bed Complement Data, Item 9.

It is noted 12 geriatric psychiatric beds will transfer from Erlanger North. Please provide a bed complement data chart for Erlanger North Hospital.

Please clarify if the proposed 88 bed psychiatric hospital will operate under the license of Erlanger Hospital. If so, how will a joint venture with Acadia impact being licensed under Erlanger Health System?

Response

Erlanger Behavioral Health will be licensed separately from *Erlanger Medical Center*.

A bed complement chart for *Erlanger North Hospital* is below.

Bed Type	Erlanger North
Medical	27
Surgical	14
Long-Term Care Hospital	
Obstetrical	
ICU / CCU	4
Neonatal ICU	
Pediatric	
Adult Psychiatric	
Geriatric Psychiatric	12
Child / Adolescent Psychiatric	
Rehabilitation	
Nursing Facility (non-Medicaid Certified)	
Nursing Facility Level 1 (Medicaid only)	
Nursing Facility Level 2 (Medicare only)	
Nursing Facility Level 2 (dually certified – Medicaid / Medicare)	
ICF / MR	
Adult Chemical Dependency	
Child & Adolescent Chemical Dependency	
Swing Beds	
Mental Health Residential Treatment	
Residential Hospice	
TOTAL	57

3.) Section A, Applicant Profile, Item 13.

It is noted the applicant and one other provider are enrolled in Blue Network S, and Erlanger is the only provider enrolled in Network E. What is the name of the other provider enrolled in Network S? Please provide a source for enrollment numbers provided for both networks.

Please define Blue Network E and Blue Network S and provide an overview of behavioral and substance abuse benefits covered under each plan.

What is Blue Network P?

The applicant references behavioral health organizations (BHOs). Please name the BHOs the applicant is referencing.

Response

The other provider in Chattanooga which is enrolled in *Blue Network S* is *Parkridge Health System*. The source of enrollment data for *Blue Network E* and *Blue Network S*, was information provided by *Blue Cross / Blue Shield* leadership.

Blue Network E is described on the *Blue Cross / Blue Shield of Tennessee* website as the "*Essential*" network. *Blue Network S* is described as the "*Select*" network. *Blue Network P* is described as the "*Preferred*" network.

Generally, behavioral health benefits are a covered service through the *Blue* networks when they are received from a contracted provider or a non-contracted provider depending on the member's health care benefit plan. Program services are covered when received in a licensed behavioral health facility program, or unit for mental health disorders or substance use disorders and when prior authorization is given by the member's health care benefit plan. Program services include acute care, residential care, partial hospitalization, intensive outpatient programs, and inpatient and outpatient electroconvulsive therapy (ECT).

As part of the *HSDA* form pertaining to Section A, Item 13, reference is made to *Behavioral Health Orgnization's* which are part of the TennCare program. Applicant's

mention of "other BHO's" is a reference to this item. Upon review of the *TennCare* website, it does not at this point in time list any specific *BHO's*, however, applicant will endeavor to contract with any mental health payor organization which participates in the *TennCare* program.

4.) Section B, Project Description, Item 1.

It is noted the applicant Erlanger Behavioral Health will be initially owned by Erlanger Health System. In addition, it is noted the proposed facility will in the future become a joint venture ownership arrangement between Erlanger Health System and Acadia Healthcare. However, please address the following:

- Why did the applicant not form a joint ownership agreement prior to filing an application for a Certificate of Need?
- Will there be a future management company?
- Will the future joint ownership be charged management fees?
- What is the timeframe of the future joint ownership?
- What is the involvement of Acadia in the development and filing of this application for a Certificate of Need?
- What will be Acadia Healthcare's percentage of Erlanger Behavioral Health, LLC ownership?

If approved, please clarify if the applicant will be classified as a safety net provider by the Tennessee Department of Mental Health and Substance Abuse Services.

What type of outpatient, intensive outpatient, and partial hospitalization programs are associated with this proposed project?

Please clarify if the proposed eighty-eight (88) bed inpatient psychiatric hospital will be classified as an Institution for Mental Disease (IMD) licensed by the Department of Mental Health, or will be licensed as a department of Erlanger Health System and licensed by the Department of Health.

Please describe the applicant's experience in

operating the following:

- An Adult Inpatient Chemical Dependency Unit
- An Adult Psychiatric Unit
- An Child and Adolescent Inpatient Psychiatric Unit
- A Gero-Inpatient Psychiatric Unit

The applicant notes there are a total of 252 licensed inpatient beds in the proposed service area. Does this number include licensed beds at Moccasin Bend Mental Health Institute (MBMHI)? If not, what is the number of licensed beds with MBHMI included?

It is noted Acadia Healthcare will fund the $25,112,600 proposed project. If so, please provide the documentation that obligates Acadia Healthcare to fund the proposed project.

Response

Erlanger has been in discussion with *Acadia* but only recently crafted and agreed to a *Letter of Intent*. *Erlanger* was well aware of the need for additional behavioral health services and has been working to address this need in an effective manner. Approval was received from the *US Health Resources & Services Administration* to initiate behavioral health at our FQHC sites approximately three years ago. We also added a psychiatry division with psychiatrist and placed LCSW's in our Emergency Department to address the large volume of patients with co-existing medical and behavioral health conditions. With a large volume of patients currently served, we believe the timing is right to move forward with the filing of the *Certificate of Need*, now that the *Letter of Intent* has been completed. We expect to be working to develop the joint venture concurrently with the review of the *Certificate of Need*.

A copy of the *Letter of Agreement* between *Erlanger Health System* and *Acadia Healthcare* is attached to this supplemental information. The agreement specifies a two (2) stage process that will be followed for development of this project.

There will not be a future management company, the CON application specifies that management officers will be hired by *Erlanger Behavioral Health*. There will not be

"management fees", per se, as understood in the traditional sense of that term because the officers will be hired directly by *Erlanger Behavioral Health*. However, there will be "fees" from *Acadia* for support services to *Erlanger Behavioral Health*, equal to 2% of net revenue as outlined in paragraph eight (8) of the agreement. The 2% fees were not identified and were inadvertently included in *Other Expenses* on the *Projected Data Chart*. For this reason we have included a replacement page 57 for the *Projected Data Chart*.

As specified in the *Letter of Agreement*, the second stage of project development will include determination of specific details after the CON is approved. It is anticipated that the time period necessary to conclude these detail discussions will be 60 to 90 days, or less.

The involvement of *Acadia* in development and filing the CON application is to provide the architectural and engineering support, as well as necessary information pertaining to operation of a psychiatric hospital, such as the financial information. A majority of the preliminary development work has been conducted by *Erlanger*, with collaboration by Acadia, such as site selection, etc.

As of this point in time, it is unknown precisely what *Acadia's* ownership percentage will be. *Erlanger* and *Acadia* will work with an independent valuation consultant to determine proportional ownership interests by the respective parties.

Erlanger Behavioral Health will serve the defined service area as a "safety net provider" as that term is generally understood, this is outlined in the *Letter of Agreement* between *Erlanger* and *Acadia*. While the *Dept. Of Mental Health* does not have such a designation as does the *Bureau of TennCare*, applicant will operate in such a manner which "recognizes and promotes *Erlanger's* objective of providing charity care". (Please see paragraph 7 of the *Letter Of Agreement*.)

Erlanger Behavioral Health will be classified and licensed as an Institution for Mental Disease (IMD) licensed by the *Dept. of Mental Health*, not as a department of *Erlanger Medical Center*.

As a newly established provider, *Erlanger Behavioral Health* will draw upon the experience of both *Erlanger* and *Acadia* in operating psychiatric programs. *Erlanger North Hospital* currently operates an inpatient geriatric psychiatric program, to be relocated to the new hospital, and *Acadia* has experience in the operation of adult psychiatric units, child and adolescent inpatient unit and adult chemical dependency programs with 585 facilities worldwide. *Erlanger* also has a psychiatric division with employed psychiatrist and provides service to inpatients as well as children in the emergency department and its *Federally Qualified Health Centers*.

The analysis of current bed supply in the service area presented in the CON application does not include *Moccasin Bend Mental Health Institute*. The number of beds at *MBMHI* is 150. It should be noted that *MBMHI* service area is the 52 counties in East Tennessee extending as far north as the Virginia and Kentucky state lines; the service area for Erlanger Behavioral Health is only 18 counties in Southeast Tennessee. The beds at *MBMHI* are utilized for patients with long term mental health issues, not those generally served in community based programs. Further, it is noted that in the *Agency's* staff report for the *Crestwyn Behavioral Health* application (no. CN1310-040), it was stated that "traditionally, the State operated mental health institutions care for long term mental health patients". Also, that "the applicant did not assess the impact the proposal would have on either of the State facilities".1

As to *Acadia's* obligaton to fund the project, please see paragraph 3(c) of the *Letter of Agreement* which specifies that *Acadia* will pay for design & construction, etc.

5.) Section B, Project Description, Item II.A.

Please clarify if the eighteen adolescent and child unit will be coed. If so, how and when will females and males be segregated?

Please clarify if all the proposed psychiatric units will be locked.

1 See *Application Summary* by *HSDA* staff dated October 13, 2013, p. 4, Item C-3, *Crestwyn Behavioral Health*, CON No. CN1310-040.

What are the proposed age ranges for each of the three proposed psychiatric units and adult chemical dependency unit?

Response

The child & adolescent unit of *Erlanger Behavioral Health* will be co-ed. Generally, males will be assigned to rooms on one side of the hallway and females will be assigned to rooms on the other side of the hallway.

Each of the proposed units within the facility will be locked.

The proposed age ranges for the units are as follows.

Unit Description	Age Range
Child / Adolescent	0-17
Adult	18-64
Geriatric	65+
Adult Chemical Dependency	18-64

6.) Section B, Project Description Item III.A.(Plot Plan).

The plot plan is noted. Please provide a revised plot plan that includes the size of site (in acres).

Response

A revised plot plan with the size of the site (in acres) is attached to this supplemental information.

7.) Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services A. Need, 1).

Please include Moccasin Bend Mental Health Institute's licensed beds in the bed calculations on page 33, and in the tables and narrative response on page 34 and submit a replacement page. The Guidelines for Growth does not exclude state Mental Health Institutes in determining psychiatric bed need.

Please reference the data source the applicant used to determine the bed need in the proposed service area.

Response

As requested, *MBMHI* has been added to the inventory of current bed supply for psychiatric services in the defined service area. The data source for population information in this analysis was obtained from *Claritas*, a leading provider of demographic data. Population data was not available on the *Tennessee Dept. of Health* website. The replacement pages (34-36) are attached to this supplemental information.

However, applicant will point out that information on the *MBMHI* website indicates that …

> "*MBMHI* assists patients who are not typically served by the private service sector and have no other inpatient treatment resources available to them."

Thus, *MBMHI* itself categorically states that it does serve those who are covered by the private service sector.

It should be noted that *MBMHI* service area is the 52 counties in East Tennessee extending as far north as the Virginia and Kentucky state lines; the service area for *Erlanger Behavioral Health* is only 18 counties in Southeast Tennessee. The beds at *MBMHI* are utilized for patients with long term mental health issues, not those generally served in community based programs. Further, it is noted that in the *Agency's* staff report for the *Crestwyn Behavioral Health* application (no. CN1310-040), it was stated that "traditionally, the State operated mental health institutions care for long term mental health patients". Also, that "the applicant did not assess the impact the proposal would have on either of the State facilities".

8.) Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services A. Need, 3).

What is the calculated bed need for child/adolescents ages 0-17? Please describe the age range of patients served by the proposed child adolescent psychiatric program.

Response

The need information presented in the CON application indicates that there is an over supply of five (5) child/adolescent psychiatric beds in the defined service area for the age group 0-17. However, it should be noted that *Parkridge Valley Hospital for Children & Adolescents*, had a utilization rate of 79.6%, or 80.0%, for CY 2014.[2] From a health planning perspective, the threshold for consideration of additional beds in a service category is traditionally 80.0%.

Erlanger Behavioral Health will serve children and adolescents with emotional and behavioral health problems, of all ages. Individualized care plans will provide a foundation for stabilization for those in crisis or otherwise in need of this service. The professional team will collaborate with outpatient treatment providers and provide patient and family education to ensure those involved with the patient's care understand emotional health issues as well as symptom management. For this age group, family involvement is crucial.

9.) Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services B.1. (Service Area).

Please submit an online request to the Tennessee Department of Health, Division of Health Statistics, requesting patient discharge utilization data (inpatient day or discharge patient days) for the most recent year available by MCD19 (Mental Diseases and Disorders) and MCD 20 (Alcohol/Drug Abuse & Alcohol/Drug-Induced Organic Mental Disorders) by patient origin by facility by county for the proposed service area. Please include the data in a table listing the facility and associated inpatient days or discharge patient days for the age groups 0-17, 18-64, and 65+.

Response

The number of inpatient days by county of patient origin for MDC's 19 and 20, is attached to this supplemental request.

---

2 The calculation for utilization is 86 average daily census divided by 108 psychiatric beds, this information is derived from the *Joint Annual Report* for CY 2014, p. 23.

SUPPLEMENTAL #2
March 28, 2016
11:49 am

10.) Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services) B. 2. Service Area Demographics and Section C. Need. Item 4.A Service Area Demographics.

Please complete the following chart for each county in the proposed service area.

Demographic Data	County #1	County #2	Etc.	Service Area Total	State of TN Total
0-17 Population-2016					
0-17 Population-2020					
0-17 Population % Change					
0-17 Population % of Total Population					

Response

As requested, the table has been completed.

SUPPLEMENTAL #1
March 28, 2016
11:49 am

Erlanger Bevioral Health -- 0-17 Age Group Demographics

	0-17 Pop. CY 2016	0-17 Pop. CY 2020	0-17 Pop. % Change	0-17 Pop. % Of Total -2016	0-17 Pop. % Of Total -2020
Hamilton County, TN	76,469	78,962	3.3%	22.2%	22.7%
Bradley County, TN	22,712	22,612	-0.4%	6.6%	6.5%
Marion County, TN	3,533	5,811	64.5%	1.0%	1.7%
Grundy County, TN	2,891	2,758	-4.6%	0.8%	0.8%
Sequatchie County, TN	3,366	3,406	1.2%	1.0%	1.0%
Bledsoe County, TN	2,544	2,437	-4.2%	0.7%	0.7%
Rhea County, TN	8,897	8,952	0.6%	2.6%	2.6%
Meigs County, TN	2,339	2,213	-5.4%	0.7%	0.6%
McMinn County, TN	11,293	11,045	-2.2%	3.3%	3.2%
Polk County, TN	3,493	3,352	-4.0%	1.0%	1.0%
Dade County, GA	3,262	3,118	-4.4%	0.9%	0.9%
Walker County, GA	15,052	14,548	-3.3%	4.4%	4.2%
Catoosa County, GA	15,258	14,909	-2.3%	4.4%	4.3%
DeKalb County, AL	17,601	17,268	-1.9%	5.1%	5.0%
Jackson County, AL	11,213	10,768	-4.0%	3.3%	3.1%
Chatooga County, GA	5,419	5,168	-4.6%	1.6%	1.5%
Fannin County, GA	4,311	4,263	-1.1%	1.3%	1.2%
Gilmer County, GA	5,241	6,048	15.4%	1.5%	1.7%
Gordon County, GA	14,355	14,197	-1.1%	4.2%	4.1%
Murray County, GA	9,911	9,570	-3.4%	2.9%	2.8%
Whitfield County, GA	28,674	29,927	4.4%	8.3%	8.6%
Cherokee County, NC	4,842	4,694	-3.1%	1.4%	1.4%
Coffee County, TN	12,589	12,511	-0.6%	3.7%	3.6%
Cumberland County, TN	10,642	10,820	1.7%	3.1%	3.1%
Franklin County, TN	8,363	8,069	-3.5%	2.4%	2.3%
Loudon County, TN	10,082	10,266	1.8%	2.9%	3.0%
Monroe County, TN	9,834	9,708	-1.3%	2.9%	2.8%
Roane County, TN	10,020	9,351	-6.7%	2.9%	2.7%
Van Buren County, TN	1,026	965	-5.9%	0.3%	0.3%
Warren County, TN	9,483	9,421	-0.7%	2.8%	2.7%
Total >>>>	344,715	347,137	0.7%	100.0%	100.0%

11.) Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services C. 1. Relationship to existing applicable plans (State, City, County, Regional Plans)

Other than the Tennessee Guidelines for Growth, are there other existing applicable plans (city, county, and/or regional) that has a relationship to the proposed project? Please clarify.

Response

Applicant is not aware of any other "plans" that have a relationship to this proposal. We checked the *Chattanooga-Hamilton County Regional Planning Agency*, the *City of Chattanooga*, and *Hamilton County*. While we were not able to identify any "plans", per se, we have been able to validate certain other pertinent information relating to this project.

For instance, in 2015 the *Hamilton County Health Dept.* published a report titled "*Picture Of Our Health - Hamilton County, Tennessee - 2015 Community Health Profile*". This report presents a "snapshot" of the community's health. The suicide rate is cited as having increased by 27.3% between 2000 and 2015, from a rate of 11.3 per 100,000 to a rate of 14.4.

The *Tennessee Dept. of Mental Health* 2015 Data Book, states that *Tennessee* ranks in the bottom 10 states in the nation, for the following indicators of behavioral health.

- Adults that smoke everyday.
- Adults limited in activity due to physical, mental or emotional problems.
- Adults with mental illness in the past year.
- Youth that used methamphetamine 10 or more times during their lifetime.
- Youth that used prescription drugs without a doctor's prescription.

The *National Institute of Mental Health* reports on it's website that the prevalence of Schizophrenia is 1.1% of the general population, and 60% of those will utilize some form of healthcare service in a year. Therefore, within the defined service area for this *Erlanger Behavioral Health*, a total of 17,285 people have Schizophrenia and 10,371 will utilize healthcare services each year.

These indicators all point to the acute need for *Erlanger Behavioral Health*.

12.) Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services C. 4. Relationship to existing applicable plans (Involuntary Admissions).

Does the applicant expect to accept all involuntary admissions (all ages)? Will the applicant have the expertise and staff to monitor patients who may require one to one observation or may require special treatment?

Please discuss examples of when the applicant could not accept an "Involuntary Admission." In a situation where the applicant could not take an "Involuntary Admission", what protocols would the applicant enact to assure the patient could receive proper treatment?

Response

Generally, applicant will accept all involuntary admissions, to include all ages. However, this policy is subject to bed availability within the facility, the hospital's current staffing and treatment loads, etc. *Erlanger Behavioral Health* will have appropriate expertise and staff to monitor patients on a one to one basis, if needed.

In case an involuntary admission cannot be accepted, for the reasons cited above, *Erlanger Behavioral Health* will work with the referring source to identify alternative placement.

13.) Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services D.1. (Relationship to Existing Similar Services).

The narrative response on page 40 and utilization tables on page 41 are noted. However, please include MBMHI in the narrative response and utilization tables and submit a replacement page. In addition, please add a column in the tables to show % change from 2011 to 2014.

Response

As requested, *MBMHI* has been added to the table and the trend has been calculated between 2011 - 2014. The replacements for pages 40 and 41 are attached to this supplemental information.

However, applicant will point out that information on the *MBMHI* website indicates that …

> "*MBMHI* assists patients who are not typically served by the private service sector and have no other inpatient treatment resources available to them."

Thus, *MBMHI* itself categorically states that it does serve those who are covered by the private service sector.

It should be noted that *MBMHI* service area is the 52 counties in East Tennessee extending as far north as the Virginia and Kentucky state lines; the service area for *Erlanger Behavioral Health* is only 18 counties in Southeast Tennessee. The beds at *MBMHI* are utilized for patients with long term mental health issues, not those generally served in community based programs. Further, it is noted that in the *Agency's* staff report for the *Crestwyn Behavioral Health* application (no. CN1310-040), it was stated that "traditionally, the State operated mental health institutions care for long term mental health patients". Also, that "the applicant did not assess the impact the proposal would have on either of the State facilities".

14.) Section C, Need, Item 4.

Please provide overall patient origin by county for Erlanger Medical Center for the most recent year available. Include each county in Erlanger Behavioral Health's proposed service area.

Response

As requested, the patient origin by county for CY 2015 is below.

EHS -- In-Patient Origin By County
CY 2015

PSA Svc Area	HAMILTON, TN	15,499	*Tertiary Svc Area*	DEKALB, AL	372
				JACKSON, AL	516
				CHATTOOGA, GA	74
SSA Svc Area	BRADLEY, TN	2,110		FANNIN, GA	330
	MARION, TN	1,300		GILMER, GA	146
	GRUNDY, TN	333		GORDON, GA	207
	SEQUATCHIE, TN	909		MURRAY, GA	296
	BLEDSOE, TN	979		WHITFIELD, GA	667
	RHEA, TN	1,135		CHEROKEE, NC	218
	MEIGS, TN	196		COFFEE, TN	116
	MCMINN, TN	463		CUMBERLAND, TN	56
	POLK, TN	393		FRANKLIN, TN	215
	DADE, GA	616		LOUDEN, TN	17
	WALKER, GA	1,969		MONROE, TN	60
	CATOOSA, GA	1,692		ROANE, TN	16
				VAN BUREN, TN	51
				WARREN, TN	124

Svc Area	Cases	%
PSA	15,499	46.2%
SSA	12,095	36.1%
TSA	3,481	10.4%
All Other	2,470	7.3%
Total >>	33,545	100.0%

15.) Section C, Need, Item 5.

The utilization tables on page 50 are noted. However, please include utilization data for MBMHI in the tables and resubmit a replacement page. In addition, please include a column indicating the % change from 2011-2014.

Response

As requested, *MBMHI* has been added to the table and the trend has been calculated between 2011 – 2014. The replacements for pages 50 is attached to this supplemental information

However, applicant will point out that information on the *MBMHI* website indicates that …

> "*MBMHI* assists patients who are not typically served by the private service sector and have no other inpatient treatment resources available to them."

Thus, *MBMHI* itself categorically states that it does serve those who are covered by the private service sector.

It should be noted that *MBMHI* service area is the 52 counties in East Tennessee extending as far north as the Virginia and Kentucky state lines; the service area for *Erlanger Behavioral Health* is only 18 counties in Southeast Tennessee. The beds at *MBMHI* are utilized for patients with long term mental health issues, not those generally served in community based programs. Further, it is noted that in the *Agency's* staff report for the *Crestwyn Behavioral Health* application (no. CN1310-040), it was stated that "traditionally, the State operated mental health institutions care for long term mental health patients". Also, that "the applicant did not assess the impact the proposal would have on either of the State facilities".

16.) Section C, Need, Item 6.

Please provide the details regarding the methodology used to project 8,798 patient days during the first year of operation and 17,481 patient days during the second year of operation. The methodology must include detailed calculations or documentation from referral sources.

The total average daily census of 24.1 in Year One and 47.9 in Year Two of the proposed project is noted. Please break-out the proposed average daily census by Unit:

	Year One-ADC	Year Two-ADC
Adult Psychiatric Unit (24 beds)		
Gero Psychiatric Unit (24 Beds)		
Child and adolescent beds		

(18 beds)		
Chemical Dependency Unit (22 beds)		
Total	24.1	47.9

Please provide letters of referral from Community Mental Health Centers, Private Psychiatrists and Primary Care Physicians, etc.

Response

The ADC table has been completed.

	== Average Daily Census ===	
	Year 1	Year 2
Adult Psychiatric Unit (24 beds)	4.0	10.0
Gero Psychiatric Unit (24 beds)	12.0	18.0
Child & Adolescent Unit (18 beds)	4.0	10.0
Chemical Dependency Unit (22 beds)	4.1	9.9
Total	24.1	47.9

As requested, we have attached letters of support for *Erlanger Behavioral Health*. We have also attached comments from the general community which express *overwhelming* support for *Erlanger Behavioral Health* … these comments have appeared on websites in Chattanooga as well as other social media, such as *Facebook*.

17.) Section C. Economic Feasibility Item 1 (Project Cost Chart).

Line D. listing the estimated project cost as $24,067,600 is incorrect. Please revise and provide a replacement page.

Response

As requested, the error on the *Project Cost Chart* has been corrected. The replacement for page 52 is attached to this supplemental information request.

18.) Section C. Economic Feasibility Item 2 (Funding).

The March 11, 2016 funding letter from Acadia Healthcare referencing a proposed joint venture between Erlanger Health System and Acadia Healthcare is noted. However, the applicant states in the application there is not a current joint venture between Erlanger Health Systems and Acadia Healthcare. Please clarify.

What guarantee does the applicant have Acadia will actually fund the proposed project while Acadia currently has no relationship with the proposed project. Please clarify.

It is noted Acadia has a revolving line of credit that will finance a portion of the proposed project. Please submit a letter from a bank that identifies the revolving credit expected interest rate, term, and any anticipated restrictions or conditions.

What percentage of the proposed project cost will be financed through cash reserves and a revolving line of credit?

Please explain the reason the applicant is not funding the proposed project.

Response

A *Letter of Agreement* between *Erlanger Health System* and *Acadia Healthcare* is attached to this supplemental information. The agreement specifies that *Acadia* will fully fund design and construction of *Erlanger Behavioral Health*. Further, the *Letter of Agreement* with *Acadia* specifies that it's contribution will be cash and we confirmed with *Acadia* that this is their plan. As such, *Acadia* does not plan to utilize a credit facility to fund this project. Please see paragraph 3(c) of the *Letter of Agreement*.

19.) Section C, Economic Feasibility, Item 9.

Please complete the following chart for Year One of the proposed project.

Payor	Gross Revenue	% of Total Revenues

Medicare		
Medicaid/TennCare		
Commercial Insurance		
Self-Pay		
Total		

Response

The chart has been completed, as requested.

Payor	Gross Revenue	% Of Revenue
Medicare	$ 3,917,249	32.6%
TennCare/Medicaid	$ 3,086,317	25.7%
Commerical	$ 3,561,135	29.7%
Self Pay	$ 1,068,341	8.9%
Other	$ 368,758	3.1%
Total	$ 12,001,800	100.0%

20.) Section C, Economic Feasibility, Item 10.

Please provide copies of the balance sheet and income statement from the most recent audited financial statements with accompanying notes for Acadia Healthcare.

Response

A copy of the Form 10-K which was filed with the *Securities & Exchange Commission* for the fiscal year ended December 31, 2015, is attached to this supplemental information. The financial statements begin on page F-1 and the Auditor's report begins on page F-3, toward the end of the SEC filing.

21.) Orderly Development, Item 1.

Please clarify if the applicant will have transfer agreements with MBMHI.

Response

It is fully anticipated that the applicant will have a transfer agreement with *MBMHI*.

22.) Section C, Contribution to Orderly Development, Item 7 c.

Please provide the latest results of a state licensure survey and/or Joint Commission survey for Erlanger Health Systems with an approved plan of correction.

Response

The most recent accreditation letter from The Joint Commission is attached to this supplemental information, as requested.

23.) Section C, Contribution to Orderly Development, Item 8 and 9.

Please respond to these two questions for Erlanger Health Systems as a whole.

Response

There are no final orders or judgments against any professional licenses for *Erlanger Health System*. Further, there are no final orders or judgments against any entity or person with more than a 5% ownership interest in *Erlanger Health System*.

There are no final civil or criminal judgments for fraud or theft against any person or entity with more than 5% ownership interest in *Erlanger Health System*.

SUPPLEMENTAL #1
March 28, 2016
11:49 am

A F F I D A V I T

STATE OF TENNESSEE |
|
COUNTY OF HAMILTON |

NAME OF FACILITY Erlanger Behavioral Health, LLC

I, Joseph M. Winick, after first being duly sworn, State under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

SIGNATURE

SWORN to and subscribed before me this 24 of March (Month), 2016 (Year), a Notary Public in and for the State of Tennessee, County of Hamilton.

NOTARY PUBLIC

My commission expires (Month/Day) My commission expires October 10, 2016, 20____.

ROBIN S. DEBOLT
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

SUPPLEMENTAL #1
March 28, 2016
11:49 am

TABLE OF ATTACHMENTS

SUPPLEMENTAL #1
March 28, 2016
11:49 am

Description	Section / Item
Quit Claim Deed	A-6
Letter Of Agreement – *Erlanger* & *Acadia*	A-6
Plot Plan	B-III-A
Inpatient Days – Tennessee Counties Of Patient Origin	C-I-a
Letters Of Support & Public Comments	C-I-6
Moccasin Bend – Website Page	C-1-a
Letter Of Accreditation – *Joint Commission*	C-II-1
CON Replacement Pages	
Acadia SEC Form 10-K	C-III-10

SUPPLEMENTAL #1
March 28, 2016
11:49 am

ATTACHMENTS

SUPPLEMENTAL #2

March 28, 2016
11:49 am

Description	Section / Item
Quit Claim Deed	A-6
Letter Of Agreement – *Erlanger* & *Acadia*	A-6

SUPPLEMENTAL #2

March 28, 2016

11:49 am

Instrument: 200804040030l
Book and Page: GI 8633 757
DEED RECORDING FEE $15.00
DATA PROCESSING FEE $2.00
CONVEYANCE TAX $0.04
PROBATE FEE $1.00
Total Fees: $18.04
User: HCDC\MSertel
Date: 4/4/2008
Time: 3:50:29 PM
Contact: Pam Hurst, Register
Hamilton County, Tennessee

Fill

This Instrument Prepared By:
Miller & Martin PLLC (WSM)
1000 Volunteer State Life Building
832 Georgia Avenue
Chattanooga, Tennessee 37402-2289

Name and Address of New Owner:	**Send Tax Bills To:**	**Map and Parcel No.:**
Medical Development Partners, LLC Mr. Jon Kinsey Kinsey Probasco Hays LLC Chattanooga Times Building, Suite 600 100 E. 10th Street Chattanooga, TN 37402	Same	146C-A-022 & 146C-A-023

8M69

QUITCLAIM DEED

FOR AND IN CONSIDERATION OF Ten Dollars ($10.00) and other good and valuable consideration, the receipt and legal sufficiency of all of which hereby are acknowledged, **CITICO MEDICAL, LLC,** a Tennessee limited liability company (herein "Grantor") does hereby remise, release and quitclaim unto **MEDICAL DEVELOPMENT PARTNERS, LLC,** a Tennessee limited liability company (herein "Grantee") the property described on **Exhibit "A"** attached hereto and made a part hereof, together with all improvements thereon and all easements, rights and privileges appurtenant thereto.

IN WITNESS WHEREOF, Grantor has executed this instrument as of the 31st day of December, 2007.

CITICO MEDICAL, LLC,
a Tennessee limited liability company

By: _____
Name: JON M. KINSEY
Title: CHIEF MGR

Content_4717568_1

6

SUPPLEMENTAL #1

March 28, 2016

Book and Page: GI 8[illegible]49 am

STATE OF TENNESSEE
COUNTY OF HAMILTON

Before me, a Notary Public in and for the state and county aforesaid, personally appeared Jon M. Kinsey, to me known (or proved to me on the basis of satisfactory evidence) to be the Chief Manager of **CITICO MEDICAL, LLC**, the within named bargainor, a Tennessee limited liability company, who acknowledged that he executed the foregoing instrument for the purposes therein contained on behalf of said company in his capacity as said Chief Manager.

WITNESS my hand, at office, this 31 day of December, 2007.

ANGIE HIATT
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

Angie Hiatt
Notary Public
My Commission Expires:

My Commission Expires February 4, 2009

STATE OF TENNESSEE
COUNTY OF HAMILTON

I, [signature], hereby swear or affirm that the actual consideration for this transfer is $10.00.

BY [signature], CHIEF MGR.
Affiant-Grantee MEDICAL DEV. PARTNERS, LLC

Subscribed and sworn to before me this 31 day of December, 2007.

Angie Hiatt
Notary Public
My Commission Expires:

My Commission Expires February 4, 2009

ANGIE HIATT
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

EXHIBIT "A"

Being a tract of land located in the City of Chattanooga, Hamilton County, Tennessee and being Tracts One (1) and Two (2) as described in Book 5570, page 845, in the Register's Office of Hamilton County, Tennessee, and being more particularly described as follows:

Beginning at an iron rod found on the eastern right-of-way of Holtzclaw Avenue, having a width that varies, being the northwest corner of the herein described property and being the southwest corner of the Tipton Properties G.P. property recorded in Book 5467, page 976 in said Register's Office; thence, leaving said right-of-way and continuing along the southern boundary of the Tipton Properties G.P. property, South 67 degrees 00 minutes 00 seconds East 478.82 feet to an iron rod set; thence, along the western boundary of the City of Chattanooga property recorded in Book 4977, page 567 in said Register's Office, South 04 degrees 13 minutes 22 seconds West 517.85 feet to an iron rod with cap found; thence, along the western boundary of the James Houston property recorded in Book 6624, page 600 in said Register's Office, South 22 degrees 47 minutes 30 seconds West 192.78 feet to an iron rod and cap found and being on the northern right-of-way of Citico Avenue, having a width of 56 feet; thence, along the northern right-of-way of Citico Avenue, North 67 degrees 00 minutes 00 seconds West 531.16 feet to a point; thence, in a curve to the right an arc distance of 29.36 feet and having a radius of 19.00 feet and subtended by a chord of North 22 degrees 43 minutes 44 seconds West 26.53 feet to a point on the eastern right-of-way of Holtzclaw Avenue; thence along the eastern right-of-way of Holtzclaw Avenue the following: North 21 degrees 32 minutes 32 seconds East 61.75 feet, North 20 degrees 35 minutes 06 seconds East 93.94 feet, North 16 degrees 17 minutes 12 seconds East 225.87 feet and North 23 degrees 09 minutes 03 seconds East 95.30 feet to the Point of Beginning. Said Tract herein described contains 6.05 acres.

The description above taken from the survey of The R.L.S. Group, dated 10/8/2004, as revised 11/5/2004, being Drawing No. 04152E. Legal description is the same as prior deed.

PRIOR AND LAST DEED REFERENCE: Book 7347, Page 895, et seq., Register's Office at Hamilton County, Tennessee.

SUPPLEMENTAL #2
March 28, 2016
11:49 am

ACADIA HEALTHCARE

Direct Phone: 615-861-7339
Email: steve.davidson@acadiahealthcare.com

February 16, 2016

By Email (Joe.Winick@Erlanger.org)
Joseph M. Winick, FACHE
Senior Vice President
Planning, Analytics & Business Development
Erlanger Health System
975 E 3rd Street
Chattanooga, TN 37403

Re: Potential Venture for 80 Bed Behavioral Hospital – Letter of Intent

Dear Joe:

This letter is Acadia Healthcare Company, Inc.'s ("Acadia's") non-binding proposal ("Proposal") to enter into a joint venture arrangement (the "Transaction") with Erlanger Health System ("Erlanger") to develop, build and operate a new 80-bed inpatient psychiatric facility (the "Facility") that would provide a full range of inpatient and outpatient behavioral health services, on or near the Erlanger campus.

1. **Proposed Transaction Structure.** Based upon the information available to us to date, Acadia anticipates a two stage transaction structure. During the first stage, Erlanger would form a new entity (the "Venture") to own and operate the Facility which, initially, would be wholly-owned by Erlanger. The parties rights and obligations during the first stage would be governed by a Pre-Organizational Agreement. Upon obtaining a final, non-appealable Certificate of Need to develop and operate the Facility (the "CON"), the Transaction would enter the second stage during which Acadia would become an owner of the Venture and the Facility would be developed. The parties rights and obligations during the second stage will be governed by an Operating Agreement.

2. **First Stage Responsibilities.** During the first stage, Erlanger, at its expense, will organize the Venture and will apply for and pursue obtaining the CON. Erlanger will pursue the CON to a final, non-appealable result. The parties acknowledge that Acadia's intended relationship with the Venture will need to be disclosed during the CON process. Acadia will incur the costs of architecture, engineering and design necessary for the CON application for the Facility. Additionally, Acadia will deliver a letter to the Venture which will outline its commitment to fund the construction and development of the Facility which the Venture may use in connection with the CON application. The Venture shall obtain or shall obtain the right to acquire the real

estate for the Facility. Erlanger and Acadia would share equally, if necessary, the cost of an option on the real estate for the Facility.

3. **Second Stage Responsibilities.**

a. **Ownership of the Venture.** Upon the Venture obtaining a final and non-appealable CON, Acadia will become a member of the Venture. Erlanger and Acadia would own a percentage interest in the Venture in proportion to the value of their respective contributions. The value of the contributions, and the resulting relative percentage ownership of the Venture would be based upon an independent fair market valuation.

b. **Profit and Loss.** Each member's share of profits, losses and distributions in the Venture would be proportional to that member's percentage interest in the Venture.

c. **Contributions.** For its capital contribution to the Venture, Acadia would contribute cash in an amount to be determined; to be used for the design and construction of the Facility. For its capital contribution to the Venture, Erlanger would contribute its geriatric-psych business operated at Erlanger North Hospital and the Erlanger brand name for the Facility. Additionally, Erlanger will be credited with the value that the Venture has relating to the fair market, appraised value of the CON and the real estate for the Facility.

d. **Definitive Agreements.** The obligations of the parties to consummate the Transaction would be set forth in "Definitive Agreements" acceptable to each party in its sole discretion. The Definitive Agreements would detail the parties' rights and responsibilities concerning capital contributions, pro rata profit distributions, duties owed to the entity and the minority members, restrictions on transfers of interests, put and call rights, other restrictive covenants, triggers for the unwinding of the Venture, and other customary terms and conditions for a transaction of this type. The initial Definitive Agreement would be the Venture's Pre-Organizational Agreement which will have the form of the Operating Agreement for the Venture (the "Operating Agreement") and a license agreement for the Erlanger brand name attached. It is contemplated that the Operating Agreement would be fully negotiated at the outset of the Transaction but would be signed upon obtaining the CON.

e. **Working Capital Financing.** The Venture would not incur any debt other than a line of credit from Acadia, commencing upon obtaining the CON, of up to $5,000,000 for (i) working capital; (ii) general corporate purposes; and (iii) startup expenses. The parties contemplate that the Venture will purchase the real estate on which the Facility will be located using this capital, or, in the alternative, that Acadia will acquire such real estate and contribute it to the

Venture. The line of credit would bear interest at the prime rate plus 2%, would be due in full in 60 months, and would be repaid in full before distributions of profit by the Venture. The Venture would not guarantee debt of Acadia or Erlanger.

4. **Closing Conditions.**

a. The stage one closing would be conditioned on the following:

1. execution and delivery of Definitive Agreements;
2. approval of the Transaction by Acadia's Board of Directors;
3. approval of the Transaction by Erlanger's Board of Directors;
4. regulatory, legal, and operational diligence approval by Erlanger; and
5. regulatory, legal, and operational diligence approval by Acadia.

b. The stage two obligations of the parties including the requirement for Acadia to fund construction and the requirement for Erlanger to contribute its geriatric-psych unit to the Venture shall be conditioned on the following:

1. no material adverse change in the CON, licensure category, or the prospects of the Facility;
2. approval of a CON for the Facility for at least 80 psychiatric beds;
3. zoning and similar land use approvals for the Facility's construction issuing from the appropriate governmental authorities;
4. receipt of a written opinion or opinions from independent third party appraiser(s) with expertise in healthcare transactions, that the consideration paid or contributed in exchange for member interests in the Venture is consistent with fair market value.

5. **Governance.** Beginning with stage two, the Venture would be subject to oversight by a "Board of Directors" appointed by the parties and voting based on the respective ownership interests represented, provided that in no event shall any party have less than two Board members. It is anticipated Acadia would have a controlling interest in the Venture and appointment rights over a majority of the Board of Directors. The following Board of Directors decisions would require approval of (a) a majority of the appointed individuals sitting on the Board of Directors and (b) at least one Board representative of each of the parties:

a. approving the Venture's strategic business plan;
b. determining the need for additional capital contributions;
c. approving the location and design of the Facility and construction budgets;
d. extraordinary capital expenditures including long term leases;
e. approving incurrence of extraordinary debt;
f. expanding or reducing the number of beds at the Facility;
g. admitting any new member;

h. creating or issuing additional membership interests and/or new classes of membership interests;
i. granting any lien or security interest (except for those in the ordinary course of business not in excess of $1,000,000) on or in any of the Venture's assets or property;
j. making loans to, or acquiring equity interests in, any other person or entity;
k. selling or otherwise disposing of assets of the Venture, other than in the ordinary course of business;
l. agreeing to any contract restricting the Venture's right to make distributions to its members, or agreeing to pay any distributions in respect of member units in any form other than cash or in any manner other than to the members in accordance with their membership percentage interests;
m. amending the Venture's articles or organization, operating agreement, or name;
n. entering into, renewing or terminating any lease, contract or agreement or any other transaction or arrangement (whether or not involving payments or remuneration) between the Venture and any member or affiliate of a member;
o. approving any transfer of the equity interests held by a member, whether by direct sale, merger, or exchange;
p. approving any merger, sale, restructuring, or recapitalization of the Venture or causing the Venture to convert to a different form of entity;
q. filing a petition requesting or consenting to an order for relief under the federal bankruptcy laws or to dissolve the Venture;
r. leasing any portion of the real property owned by the Venture other than in the ordinary course of business;
s. redeeming or repurchasing by the Venture of any member units, other than on a pro rata basis to all members;
t. hiring and retention of the CEO, CFO and CNO of the Facility;
u. entering into any corporate integrity agreement or settlement agreement in connection with any government investigation or whistleblower suit; and
v. making other extraordinary material decisions as set forth in the Definitive Agreements.

The Definitive Agreements would include a mechanism for resolving certain deadlocks that may arise in connection with a governance decision.

6. **Financial Statements.** The Definitive Agreements will provide for the delivery of annual Acadia-level consolidated and Venture-level audited, and monthly Venture-level unaudited financial statements of the Facility.

7. **Charity Care Policy.** The Operating Agreement will contain covenants ensuring that the Venture (i) is operated and managed in a manner that does not jeopardize Erlanger's tax-exempt status, and (ii) recognizes and promotes Erlanger's objective of providing charity care. Specifically, the Operating Agreement will provide that the Venture will provide healthcare services for a broad cross-section of the community, adopt high standards for the quality of

patient care, provide a reasonable level of charity care to the community served by the Venture and collaborate with Erlanger on the provision of uncompensated care.

8. **Corporate Office Services; Management.** Pursuant to a services agreement to be entered into between the Venture and Acadia, Acadia's corporate office would provide corporate office management services to the Venture, to include support in the following areas: operations management, finance and accounting, legal advice and counsel, internal audit, clinical quality and compliance, risk management, insurance, human resources, recruiting, payroll, information technology, tax, billing and collecting, marketing, managed care contracting, and business office support. Acadia would charge the Venture a management fee equal to 2% of the Venture's revenue for these corporate office services, and would pass through to the Venture without markup the following expenses: (a) the actual reasonable costs of outside consultants, legal counsel, tax counsel and outside auditors; (b) a proportional amount of Acadia's facilities' costs for software licenses, insurance and employee benefits; and (c) the direct costs of Adadia's call center, web design and marketing staff to the extent dedicated to marketing the Facility, not to exceed .05% of annual Venture revenue, the actual reimbursable third party expenses of Acadia's corporate office staff, incurred in providing services to the Venture, in accordance with Acadia's Expense Reimbursement Policy. As the anticipated majority member, Acadia would be responsible for the day-to-day operations, management and control of the Facility. Acadia would consolidate the results of the operations of the Facility with its company financial statements.

9. **Noncompetition.** The Definitive Agreements would provide that Acadia and Erlanger would covenant and agree with one another and each other's affiliates that, during the Non-Compete Period (defined below) and within the Non-Compete Area (defined below), they would not directly or indirectly, with the exception of the Facility and specified other exceptions, own, acquire, lease, manage, consult for, serve as agent or subcontractor for, finance, invest in, own any part of or exercise management control over any facility or business that primarily provides services that are the same or similar to the services provided by the Facility, provided that the non-compete will exclude care provided by Erlanger in any emergency department or any service provided in an acute care setting which is accompanied by or incidental to a general medical condition which requires the patient's presence at an Erlanger facility. The "Non-Compete Period" would, for each member respectively, commence on the date of such member's acquiring any membership interest in the Venture (each a "Membership Date") and terminate on the second anniversary of such member's liquidation or termination of all such membership interests. The "Non-Compete Area" would mean the area within a twenty-five (25) mile radius of the Facility, including any satellite locations thereof. In addition, during the Noncompete Period, the members shall not solicit for employment or employ any person (at or above a certain level) who is then employed by the Venture or a party, subject to exceptions for general solicitation activity not targeted as such persons.

10. **Access and Information.** The parties will furnish to one another and their respective representatives such CON, licensure, regulatory and such other information relating to the Transaction as another party or its representatives may from time to time reasonably request.

All such access, investigations, contacts and inspections to be conducted by the requesting party and its representatives shall be conducted in consultation with the other parties and in such a manner as not to interfere unduly with the normal conduct of the other parties' business.

11. Confidentiality; Public Announcement. The terms of this letter are subject, in all respects, to the parties' Memorandum of Understanding July ___, 2015. The timing and content of any announcements, press releases or any public statements concerning the Transaction (including the CON process) shall be determined by mutual agreement of the parties, unless, with respect to Acadia, in the judgment of Acadia upon advice of counsel, disclosure is otherwise required by Acadia by applicable law or by the applicable rules of any stock market on which Acadia's securities are listed or quoted, provided that Acadia shall use commercially reasonable efforts consistent with such applicable law to consult with Erlanger with respect to the text thereof.

12. Exclusivity. The parties contemplate the expenditure of substantial sums of time and money in connection with legal, accounting, financial, and due diligence work to be performed in conjunction with the proposed transaction prior to execution of the Definitive Agreements. For purposes of inducing one another to execute this Letter of Intent, during the period from the date of acceptance of this Letter of Intent specified below to March 31, 2016, the parties and their directors, officers, affiliates, agents and employees shall not, without the prior written consent of the other parties hereto, directly or indirectly, solicit or entertain offers from, negotiate with, or in any manner encourage, discuss, accept or consider any proposal of any other person relating to the acquisition, construction, joint venture, or management of a psychiatric or substance abuse facility similar in nature and location to the proposed Facility.

13. Nonbinding Effect. Except as provided in paragraphs 11-15 (the "Binding Provisions"), this Letter of Intent will not create any binding legal commitments between the parties but will serve only to evidence the parties' present intentions with respect to a possible transaction.

14. Termination of Letter of Intent. This Letter of Intent shall terminate upon the earliest to occur of (i) written notice of termination by either party to the other or (ii) the execution of Definitive Agreements. The Binding Provisions shall survive the expiration or termination of this Letter of Intent.

15. Governing Law. This Letter of Intent shall be governed and construed in accordance with the laws of the State of Tennessee without regards to principles of conflicts of laws.

We are very pleased to submit this Proposal. The Transaction is a priority for Acadia and we are prepared to commit the necessary resources to complete the Transaction expeditiously. Any questions regarding this Proposal should be directed to Steve Davidson, Chief Development Officer, at 615-861-6000 or via email at steve.davidson@acadiahealthcare.com. We thank you for your consideration and look forward to working with you.

SUPPLEMENTAL #2
March 28, 2016
11:49 am

If you are in agreement with the terms of this Letter of Intent, please sign and return one copy to us and each party should retain one copy for its records.

Sincerely,

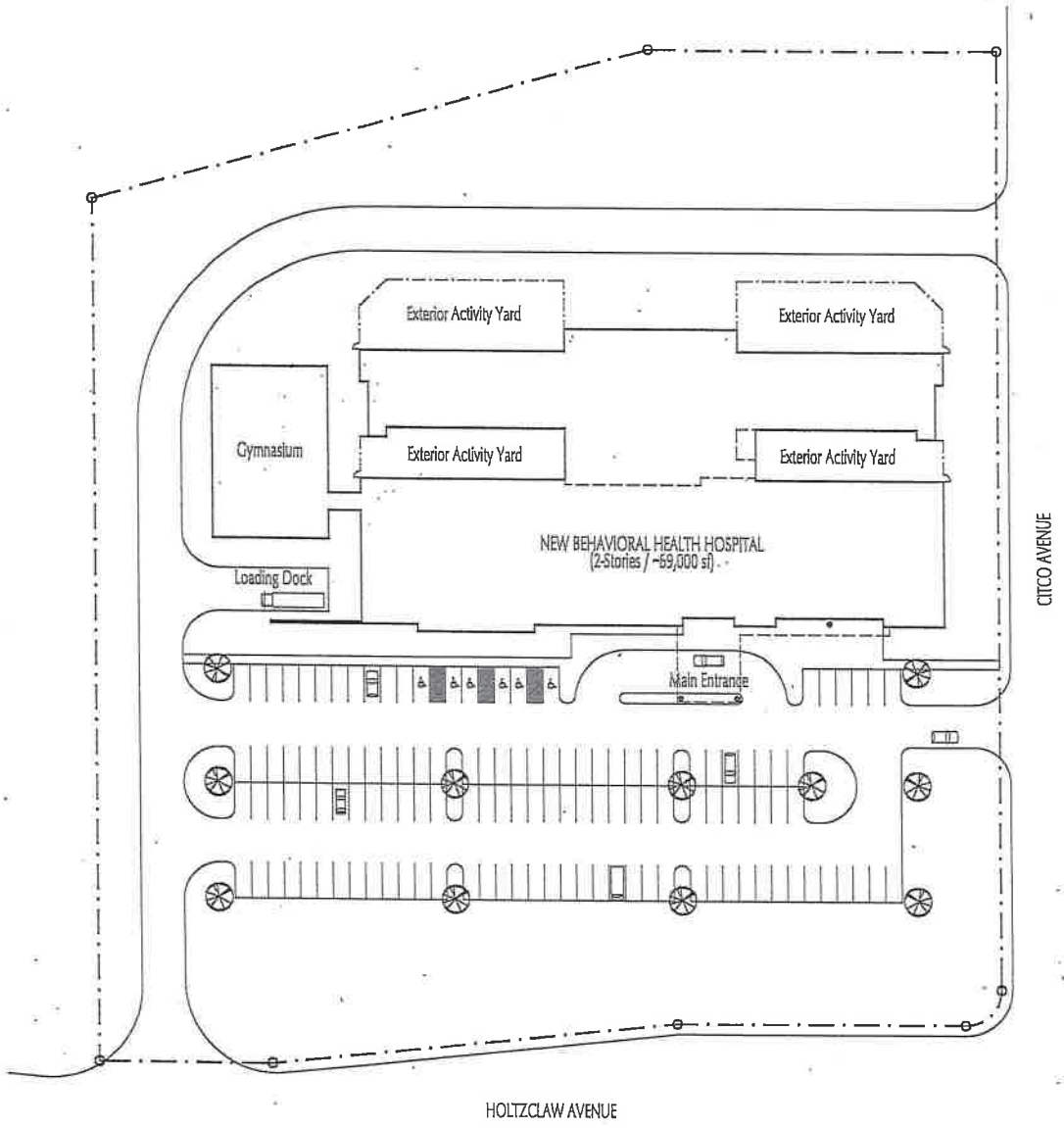
Steve Davidson
Chief Development Officer

Agreed and Accepted:

Erlanger Health System
By: Joseph M. Winck
Its: SVP

SUPPLEMENTAL #1
March 28, 2016
11:49 am

Description	Section / Item
Plot Plan	B-III-A



Approximate Size of Site

6.02 Acres

AREA SUMMARY	
New Building Area - First Floor	50,900 sf
New Building Area - Second Floor	18,100 sf
TOTAL NEW BUILDING AREA	69,000 sf

NORTH

GRAPHIC SCALE

0' 50' 100' 200'

CONCEPTUAL SITE PLAN

NEW BEHAVIORAL HEALTH HOSPITAL
ERLANGER BEHAVIORAL HEALTH, LLC
CHATTANOOGA, TENNESSEE

C001-00

AHC1504 | 14 MARCH 2016

STENGEL-HILL ARCHITECTURE

613 WEST MAIN STREET LOUISVILLE, KENTUCKY 40202 502.893.1875 502.893.1876 fax

March 28, 2016
11:49 am

SUPPLEMENTAL #2

SUPPLEMENTAL #2
March 28, 2016
11:49 am

Description	Section / Item
Inpatient Days - Tennessee Counties Of Patient Origin	C-I-a
Moccasin Bend - Website Page	C-1-a

Analysis Of Inpatient Days By County Of Patient Origin
For Mental Diseases & Substance Abuse

	======== Age Group 0-17 ========			======= Age Group 18-64 ========			======== Age Group 65+ =========		
	MDC 19 Mental Dis.	MDC 20 Sub. Abuse	Total	MDC 19 Mental Dis.	MDC 20 Sub. Abuse	Total	MDC 19 Mental Dis.	MDC 20 Sub. Abuse	Total
Hamilton, TN	2,960	1	2,961	5,995	1,279	7,274	1,405	205	1,610
Bradley, TN	721		721	2,837	529	3,366	380	24	404
Marion, TN	144		144	642	64	706	335	10	345
Grundy, TN	13		13	556	66	622	450	11	461
Sequatchie, TN	172		172	392	19	411	68	9	77
Bledsoe, TN	80		80	225	47	272	68	22	90
Rhea, TN	229		229	448	145	593	180	13	193
Meigs, TN	52		52	390	47	437	108		108
McMinn, TN	415		415	1,520	232	1,752	225	1	226
Polk, TN	13		13	342	78	420	41	4	45
Coffee, TN	230	1	231	1,558	257	1,815	618	44	662
Cumberland, TN	886		886	828	74	902	674	29	703
Franklin, TN	111		111	958	99	1,057	735	43	778
Loudon, TN	199		199	688	117	805	266	23	289
Monroe, TN	1,313		1,313	980	108	1,088	217	49	266
Roane, TN	284		284	879	129	1,008	309	9	318
Van Buren, TN	13		13	102	5	107	122		122
Warren, TN	92		92	1,042	157	1,199	558	6	564
Total	7,927	2	7,929	20,382	3,452	23,834	6,759	502	7,261

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, CON and Joint Annual Report.

SUPPLEMENTAL #2

March 28, 2016

11:49 am

Hospitals

Moccasin Bend

MBMH Patient & Visitors Information

MBMH Patient Rights & Responsibilities

Middle Tennessee

Western

Memphis

Crisis Services & Suicide Prevention

Patients & Families

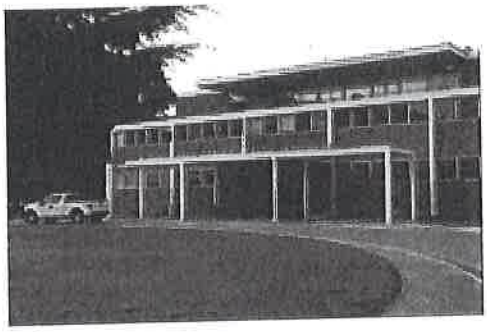
Help After Hospitalization

Jobs at the Hospitals

Moccasin Bend

Moccasin Bend Mental Health Institute

Mary C. Young, Chief Executive Officer
100 Moccasin Bend Road
Chattanooga, TN 37405
423-265-2271



ABOUT

Moccasin Bend Mental Health Institute (MBMHI) is a psychiatric hospital that serves 52 counties in East Tennessee. It was founded in 1961 in Chattanooga, Tennessee. The hospital offers 4 acute psychiatric care units and 2 long-term care units, comprising a total of 158 adult psychiatric beds. Hospitalizations are on a voluntary or involuntary basis, or patients can also be referred by the court system for pretrial evaluations.

The **mission** of Moccasin Bend Mental Health Institute is to provide quality psychiatric services to individuals with a severe and persistent mental illness. The staff works together with patients to promote recovery and ensure their successful return home and reintegration into the community.

COUNTIES SERVED

Anderson	Cumberland	Jackson	Moore	Smith
Bedford	DeKalb	Jefferson	Morgan	Sullivan
Bledsoe	Fentress	Johnson	Overton	Unicoi
Blount	Franklin	Knox	Pickett	Union
Bradley	Grainger	Lincoln	Polk	Van Buren
Campbell	Greene	Loudon	Putnam	Washington
Carter	Grundy	Macon	Rhea	Warren
Claiborne	Hamblen	Marion	Roane	White
Clay	Hamilton	McMinn	Scott	
Cocke	Hancock	Meigs	Sequatchie	
Coffee	Hawkins	Monroe	Sevier	

ADMISSION

Moccasin Bend Mental Health Institute assists patients who are not typically served by the private service sector and have no other inpatient treatment resources available to them. Most patients have a severe and persistent mental illness and are hospitalized on an emergency, involuntary basis. The hospital is an authorized provider under TennCare.

**

SUPPLEMENTAL #1
March 28, 2016
11:49 am

Description	Section / Item
Letters Of Support & Public Comments	C-I-6

SUPPLEMENTAL #2

March 28, 2016
11:49 am

erlanger
Behavioral Health

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
502 Deaderick Street, 9th Floor
Nashville, TN 37243

RE: Erlanger Behavioral Health

Dear Ms. Hill:

The majority of psychiatric patients from the surrounding Chattanooga area come to Erlanger's Emergency Department for acute emergencies. Over the last 10 years, psychiatric visits to Emergency Departments across the country have increased and ours is no exception. Since 2013, the number of patients being transferred from Erlanger's ED to psychiatric inpatient facilities has doubled, mirrored by a drastic increase in the number of boarding hours. It is widely recognized in this region that there is a wide disparity between need and available resources.

As Chief of Behavioral Health at Erlanger, I am extremely excited to give my support for the new behavioral health hospital that will expand the current capacity for mental health treatment and support in this area. This is an incredible opportunity to improve access to care for our patients with mental illness. I am proud to be a part of Erlanger who by providing these services will change the landscape of behavioral health in this community and the lives of so many people.

Sincerely,

Jennie Mahaffey, M.D.
Chief of Behavioral Health
UT Erlanger Behavioral Health
979 East 3rd Street, Ste A-443
Office:(423)778-2965
Fax: (423)778-2966

SUPPLEMENTAL #2
March 28, 2016
11:49 am

THE UNIVERSITY of TENNESSEE HEALTH SCIENCE CENTER

COLLEGE of MEDICINE

Office of the Dean
960 East Third Street
Suite 100
Chattanooga, Tennessee 37403
Tel: (423) 778-6956
Fax: (423) 778-3672

March 24, 2016

Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
502 Deaderick Street, 9th Floor
Nashville, TN 37243

Dear Ms. Hill:

Please accept the full support from the University of Tennessee College of Medicine Chattanooga for a new proposed 88 bed behavioral health hospital. As you know, this will fill a critical patient care need in our region.

Our medical school provides the third and fourth years of medical student education and our 180 residents and fellows participate in ten residency and ten fellowship programs. A critically important part of the third year curriculum is in psychiatry and these new services will significantly enhance opportunities for education. We also would be interested in exploring new opportunities for graduate medical education expansion in behavioral health should appropriate, sustainable funding sources become available.

Thank you for your consideration of this important enhancement for patient care and education.

Kind regards,

Robert C. Fore

Robert C. Fore, EdD
Professor and Interim Dean

children's
Hospital at Erlanger

SUPPLEMENTAL #2
March 28, 2016
11:49 am

T.C. Thompson Children's Hospital Campus
910 Blackford Street · Chattanooga, TN 37403
423-778-KIDS (5437)
www.erlanger.org/childrens

March 23, 2016

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
502 Deaderick Street, 9th Floor
Nashville, TN 37243

RE: Erlanger Behavioral Health

Dear Ms. Hill:

Please accept this letter of support for the Certificate of Need application that Erlanger Health System has filed to establish a new 88 bed behavioral health hospital. As the CEO of Children's Hospital at Erlanger, I am very aware of the communities need for pediatric, adolescent and adult behavioral health services. On any given day, we have multiple patients in our emergency department, or on our inpatient floor, being held while searching for any level of psychiatric or behavioral support. Many of our patients have substance abuse issues and/or are in real need of both acute and chronic psychiatric care. This problem has continued to grow and was a recent topic for our Children's Hospitals of Tennessee (CHAT) meeting in Nashville.

I have recently met with several pediatric practices and ask them what they need from our health system. The number on answer has always been, "please help us with our behavioral health patients." These services simple do not currently exist in our community.

Thank you for your consideration of this very important initiative. If further information is needed or if you have questions, please do not hesitate to contact me.

Sincerely,

Don Mueller

Don Mueller, FACHE
Chief Executive Officer
Children's Hospital at Erlanger
office: (423) 778-2298
email: don.mueller@erlanger.org

children's
Hospital at Erlanger

THE UNIVERSITY of TENNESSEE UT
COLLEGE of MEDICINE CHATTANOOGA

children's
Hospital at Erlanger

T.C. Thompson Children's Hospital Campus
910 Blackford Street Chattanooga, TN 37403
423-778-KIDS (5437)
www.erlanger.org/childrens

March 24, 2016

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
502 Deaderick Street, 9th Floor
Nashville, TN 37243

RE: Erlanger Behavioral Health

Dear Ms. Hill:

I wanted to send you a note to let you know that as the Clinical Administrator of Children's Hospital at Erlanger, I am in full support of the Certificate of Need application that Erlanger has filed to establish a new 88 bed behavioral health hospital. We have had an increase in the number of adolescent patients seen in the Children's Emergency Department over the past year. Our Pediatric Emergency physicians have spoken out repeatedly about the need that our current patients have for additional behavioral health facilities and programs. Adolescent beds for psychological issues are hard to come by and any additional beds would be a welcome addition to our area.

Thank you for your consideration of this very important initiative. If further information is needed or if you have questions, please do not hesitate to contact me.

Sincerely,

Leslie Phelps, MSHCA, BSN, RN
Clinical Administrator
Children's Hospital at Erlanger
910 Blackford Street
Chattanooga, TN 37403
Lesie.phelps@erlanger.org
423-778-6058

erlanger

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
502 Deaderick Street, 9th Floor
Nashville, TN 37243

Re: Erlanger Behavioral Health

Dear Ms. Hill:

I am writing to advise you that the primary care and specialty physicians, numbering in excess of 200, employed by Erlanger Health System, are in full support of the Certificate of Need application that Erlanger has filed to establish a new 88 bed behavioral health hospital. Our physicians have spoken out repeatedly about the need that our current patients have for additional behavioral health services, facilities and programs. Many of the patients we currently serve on an inpatient and outpatient basis have psychological, psychiatric and medical comorbidities. We have already established a behavioral health division; however, more programming and resources are needed to address the significant need in our community and the surrounding region.

Thank you for your consideration of this very important initiative. If further information is needed or you have questions, please do not hesitate to contact me.

Sincerely,

Steven H. Burkett
Sr. Vice President, Physician Services
Erlanger Health System

SUPPLEMENTAL #2

Opinion

Thank You, Erlanger, For Offering Desperately Needed Help For The Mentally Ill

Saturday, March 12, 2016

The most under-served medical conditions that exist are mental illness. We have this artificial line of separating mental health from medical illness, mostly due to insurance companies. Greedy insurance companies and ACA requirements have pushed the majority of licensed psychiatrists to a private pay system, which is contrary to the best interest of the public and leaves the poor without treatment.

The fact is mental health problems are medical problems, and licensed psychiatrists and medical physicians are required to make meaningful improvements in the stability and lives of the mentally ill.

No one is going to counsel their way out of bi-polar, and the majority of serious mental illness.

The majority of our mentally ill population are under-treated, if treated at all. The mentally ill fill the jail, comprise a large majority of the homeless, and have a much greater propensity to drug abuse and addiction. Yet, the mentally ill have the least access to medical care and treatment from qualified licensed physicians and psychiatrists.

While unfounded, public perception of mental illness is an obstacle to treatment. There is a pervasive shortage of licensed psychiatrists and facilities in Hamilton County. That is a fact - we simply do not have enough licensed psychiatrists or facilities in Hamilton County.

It is a myth that the mentally ill can be treated by simply talking to a counselor. This is a completely inadequate approach that has mass populations of the mentally ill missing appropriate and individualized evaluation and treatment. The mentally ill should have complete medical evaluations. Often times there are root medical causes that perpetuate mental illness. The mentally ill are not receiving these medical clearances to identify or rule out root medical cause.

While social workers and counselors should be a part of the equation, the drivers should be licensed medical physicians, psychiatrists, and facilities for treatment.

Problem is, we don't have enough psychiatrists or facilities in Hamilton County.

Currently, the two primary existing mental health facilities are overflowing and often times have patients stacked in their hallways. These facilities mean well, and do the best they can with completely inadequate resources to achieve even a reasonable standard of care.

SUPPLEMENTAL #2
March 28, 2016
11:49 am

The Hamilton County Jail is also housing many mentally ill patients as these treatment facilities. Sometimes, the jail is the only option.

The mentally ill have a propensity to self medicate, which is a direct path to the justice system. The relationship between drug abuse and mental illness is not a causal one. The Hamilton County Jail is the front line of mental health, and that is really messed up. I respect the job the jail is doing with virtually no resources due to our inept elected Hamilton County Commissioners that have denied funding requested by the sheriff for almost two decades. Yep, inept Hamilton County Commission, that is what I said.

The mentally ill at the jail should be receiving mental health triage by licensed professionals. Johnson Mental Health only responds if requested. If any facility in our region needed an on staff licensed mental health professional, it would be the Hamilton County jail.

Our Hamilton County Commissioners are directly responsible for the Hanoi Hilton conditions at the jail, period. Any government that allows mentally ill people to be stacked in cells urinating over one another sleeping in the floor needs to be sued for civil rights violations. Will add that to my to do list.

In short, the standard of care for the region's mentally ill is deplorable and missing the primary components of real physicians that can evaluate medical needs including medication and facilities to house the mentally ill. No one is going to counsel their way out of a large majority of mental illness.

A reasonable standard of care cannot exist within the current framework in Hamilton County that lacks access to licensed psychiatrists and facilities.

Erlanger Hospital just published that they wish to gain authority from the state of Tennessee regulatory board for a 200-bed facility. Erlanger is a real medical leader and has identified the greatest medical need in the community.

We would not send a diabetic out of an emergency room without evaluation and treatment.

Why are the mentally ill sent out of emergency rooms untreated or even given a course of action?

Erlanger Hospital, the facility you propose is greatly needed. Please share with the public what we can do to support your proposal.

Thank you, Erlanger Hospital.
April Eldson

14

March 20, 2016

Congratulations, Earl, On Your Radio Hall Of Fame Induction

To Earl Freudenberg, My heartiest congratulations in honor of your induction into the Radio Hall of Fame. You have been in my hall of fame for many, many years already. ... (click for more)

March 20, 2016

Debunking The Social Programs Myth

Social programs didn't destroy the black family. Mass incarceration and excessive, over the top policing in primarily black communities did. When those same rules and laws are deployed, applied ... (click for more)

March 20, 2016

Roy Exum: My Pal Johnny Hennen

About 10 days ago, as I sat in the pre-dawn chill like I do each day with my three prayers lists, I took my pencil and crossed my beloved friend Johnny Hennen's name off the "B" list, and moved ... (click for more)

SUPPLEMENTAL #2
March 28, 2016
11:49 am

Winick, Joe

From: Charles, Pat
Sent: Monday, March 14, 2016 2:48 PM
To: Gentry, Gregg; Winick, Joe
Subject: Incredible, positive response on media online stories re new hospital

Importance: High

The response on local media's Facebook posts to our new hospital plans has been OVERWHELMINGLY positive. Shortly after the Times Free Press posted their story online, it got 583 likes and 151 shares, with some high praise from Judge Gary Starnes. And this was from a **Saturday** story.
Channel 3's online story quickly generated 264 likes with 78 shares. Again, with several endorsements and praise from Judge Gary Starnes, who is over Chattanooga's Mental Health Court. I would be willing to bet he would write a letter of endorsement – or even accompany you to CON hearing if his schedule permitted. Channel 12's online post led to 122 likes, 29 shares.
I have never seen so many uniformly positive comments on anything (Erlanger or otherwise) in recent months. Everyone is talking about need, how long overdue this type facility is in Chattanooga. Will be glad to provide these comments to you, Joe, if you want to include in your CON reports regarding community response.
And I certainly recommend sharing these comments with our board members.

Pat Charles
Director, Corporate Communications
Erlanger Health System
Office: (423) 778-2922
Fax: (423) 778-7615

erlanger Health System

SUPPLEMENTAL #2
March 28, 2016
11:49 am

News 12 Now
March 13 at 8:39am ·

#CHANews Erlanger proposes $25M behavioral health hospital that would provide 200 jobs

Erlanger proposes $25M behavioral health hospital - News 12 Now

CHATTANOOGA, Tenn. (AP) – Chattanooga's Erlanger Health System is hoping to build a $25 million behavioral health hospital that it says would eventually...

HTTP://BIT.LY

Like **Comment** **Share**

133 Top Comments

31 shares

Write a comment...

JoAnn Antosh Temple Bless you Erlanger! Those us us who love someone with mental illness know what this hospital could mean.
Like · Reply · March 14 at 6:21pm

Susie Que Erlanger should concentrate on building the new children's hospital before they start this one.
Like · Reply · 3 · March 13 at 9:38am

Jason Whiteside Boy how I wish they'd take over Rhea Medical. It's a nice hospital, but to work there 4 1/2 years for less than 10.00 a hour for a job that even the nurses will not do is ridiculous!
Like · Reply · 2 · March 13 at 9:00am

Paula Crowe What job?
Like · Reply · March 14 at 11:54am

Write a reply...

SUPPLEMENTAL #2
March 28, 2016
11:49 am

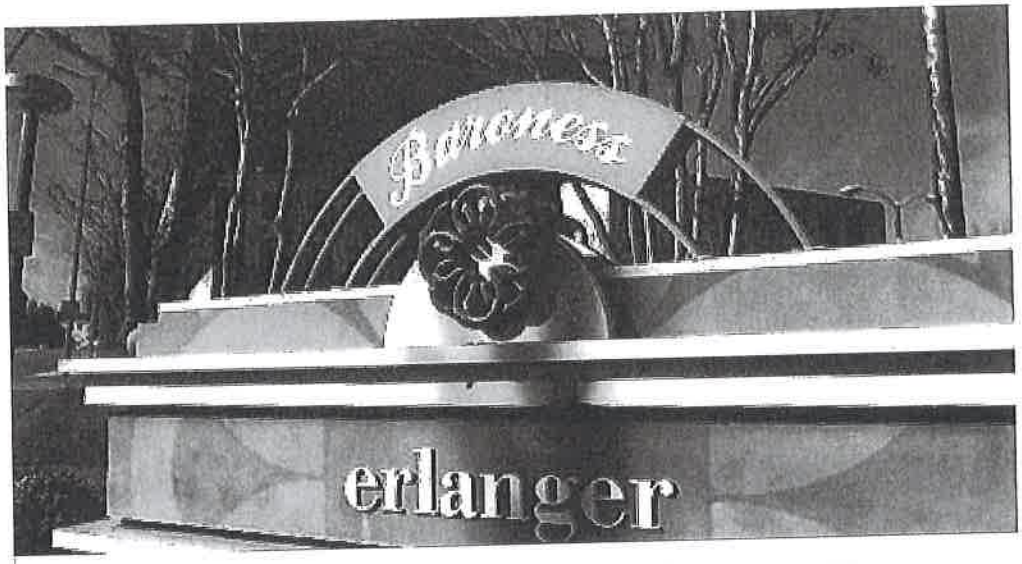
Eva Pate What a blessing that would be!!!!!

Like · Reply · March 14 at 11:15am

Write a comment...

SUPPLEMENTAL #2
March 28, 2016
11:49 am

Chattanooga Times Free Press shared a link.
March 12 at 9:00am ·



Erlanger asking for permission to build $25 million behavioral health hospital

Erlanger Health System is asking the state for permission to build a $25 million behavioral health hospital that eventually would employ 200 people, according...

TIMESFREEPRESS.COM

Like **Comment** **Share**

584

Top Comments

152 shares

Write a comment...

Heather Wilson Omg YES! Very much needed. You would be so surprised to know how many psych pts we see in our ER daily. I would be elated to see this happen!
Like · Reply · 23 · March 12 at 9:13am

Becky Hammond Praying this happens. as it is so needed in this community and across the US.mental illness needs to be recognized as an urgent medical condition.
Like · Reply · 20 · March 12 at 9:36am

Manon Kraus Whatever happened to Park Ridge Valley? That is a psyche hospital that has been in Chattanooga for some time.
Like · Reply · March 13 at 6:52pm

Heather Wilson It's still there.
Like · Reply · March 14 at 10:21am

Write a reply...

Gary Starnes Finally. This is definitely needed to address the mental health issues confronting our entire system particularly the court system. Thank you Erlanger.

SUPPLEMENTAL #2
March 28, 2016
11:49 am

Like · Reply · 8 · March 12 at 10:50am

Kymberly Brown It's needed because primary Cate doctors do not know how to treat mentally ill patients just provide you all these pills and they don't even know what pills they ate suppose to, plus you end up taking so many different ones which can make things worse. There is not many places to go here for help. They do need it.

Like · Reply · 5 · March 12 at 11:16am

Chris Beasley Certificate of Need (CON) laws are ridiculous, unconstitutional, and they hurt consumers. They are being challenged in court all over the country. In what other industry do you need permission from both the government AND your competitors to open a bus... See More

Like · Reply · 3 · March 12 at 10:22am

Tim Salmon That will have some haters who own stock in CCA highly P.O.ed.
Private prison's next step will be to open such facilities.

Like · Reply · 3 · March 12 at 1:07pm

MikeNikki Flanigan Will they actually hold ppl that need help that is the question. I've seen too many people talk there way out of help when they truly need it. -nikki

Like · Reply · 1 · March 12 at 10:29am

Jay Privett The ironic thing about libtards is that while they whine about the upper crust, the 1% that own 90% of the wealth, they are from that same 1%. These are the kind of people who look for any excuse to take the easy way out and alleviate themselves of any and all responsibility from their own mistakes. Thus voting for Bernie Sanders.

Like · Reply · March 12 at 3:27pm

John Kleinmark Yes my father gave me a small loan of 100 million and I don't know why all parents do not do this for their children.....

Like · Reply · 3 · March 12 at 10:27pm · Edited

Heather Wilson What does this comment have ANYTHING to do with this thread? Seriously. Read the actual article.

Like · Reply · 3 · March 13 at 9:21am

Jay Privett Ok dyke.

Like · Reply · March 13 at 1:59pm

Samantha Trantham Heather Wilson I agree with you. I do not think people truly understand until they see these patients first hand. Very sad.

Like · Reply · 1 · March 14 at 10:23am

Heather Wilson Jay Privett I'm married. To a man...not that it matters. Since you have nothing else better to say, or intelligent...

Like · Reply · 1 · March 14 at 10:23am

Jay Privett Mhm.

Like · Reply · March 14 at 1:41pm

Write a reply...

Tammy Steele Sure would help the community !! Please do it!!

Like · Reply · 7 · March 12 at 9:17am

Michelle Mann-Harris Yes, Moccasin Bend is still around. We are a 150 bed facility.

Like · Reply · 7 · March 12 at 9:49am

Julie Ellen Voyles And still too small to serve this community properly.

Like · Reply · 1 · March 12 at 11:33pm

SUPPLEMENTAL #1
March 28, 2016
11:49 am

Write a reply...


Heather Ward Where can I get a business card so I can hand them out to my co-workers?
Like · Reply · 4 · March 12 at 11:21am


Kim Simon Brown Yes, please. Great idea for an overlooked segment of our population.
Like · Reply · 2 · March 12 at 12:07pm


Dree Mott This would be so great!
Like · Reply · 1 · March 12 at 10:56am


Tim Warren That hospital played a big part next to God in saving my dad's life in the 70's
Like · Reply · March 12 at 6:25pm


Shawda Covington Or u could give your employees a raise since they haven't had one in yrs!!!
Like · Reply · March 12 at 1:08pm


Jennifer Tipton We just got one in January.
Like · Reply · 2 · March 12 at 3:59pm

Write a reply...


Charlie Branson Thinkin that that would be a great investment.
Like · Reply · March 12 at 2:13pm


Tiffany Harris Clarissa Souci weren't we all just talking about something like this?! Cool!
Like · Reply · 1 · March 13 at 9:55pm


Clarissa Souci Yes!
Like · Reply · 1 · March 13 at 9:56pm


Clarissa Souci I pray this happens! Much needed for sure.
Like · Reply · 1 · March 13 at 9:59pm


Tiffany Harris Me too!
Like · Reply · 1 · March 13 at 10:00pm

Write a reply...


Jose Fernandez I think that is an amazing idea. Looking forward to hear the result this June. I love Erlanger.
Like · Reply · March 12 at 10:01pm


Melissa Gannon Or what if 25 M were poured into Moccasin Bend.
Like · Reply · March 12 at 2:48pm


Chris Beasley Why would Erlanger put $25 million into a hospital owned by the State of Tennessee? Mocassin Bend also does not serve children and adolescents.

Mocassin Bend has a place as the provider of last resort for severely ill adult psychiatric patients with no family or financial support or with court ordered confinement. They don't serve the local community, they serve the regional one.

Teens with depression or an eating disorder don't go to Mocassin Bend, the two places would treat entirely different groups.
Like · Reply · 2 · March 13 at 10:12am

Write a reply...

SUPPLEMENTAL #4
March 28, 2016
11:49 am


Barry Wilson The democrats need a place to go and hang out.
Like · Reply · March 13 at 7:39pm


Terry Pickens Yes, most drivers on the road need this help.
Like · Reply · March 12 at 2:58pm


John Kleinmark Mental health clinics are recruiting stations for the Republicans.
Like · Reply · March 12 at 10:28pm


Yvonne Stoudermire Very Much Needed!!!
Like · Reply · 4 · March 12 at 9:05am


Olivia Long Woohoo!
Like · Reply · 1 · March 12 at 10:55am


Brenda Rayburn Wingo Very, very needed! I hope it is approved.
Like · Reply · March 12 at 5:23pm


Monique Dion Well needed
Like · Reply · March 12 at 10:17am


Diana Ledford Carlock It is truly needed
Like · Reply · March 12 at 3:41pm


Kristi Wilkey This is so needed!
Like · Reply · March 12 at 9:10pm


Aaron Kyle Buchanan Build it!
Like · Reply · March 13 at 8:43am


Bobby Stewart Jr. Let it happen
Like · Reply · March 12 at 6:37pm


Julie Ellen Voyles It's about time!!!!
Like · Reply · March 12 at 11:32pm


Alma Knowles Please build I
Like · Reply · March 12 at 9:44am


Melanie Bohannon Oliver Much needed!!!!
Like · Reply · March 12 at 10:25am


Dusty Horne Awesome!
Like · Reply · March 12 at 7:56pm


Zena Hanner Great!!
Like · Reply · March 12 at 4:42pm


Jodi Shapuras Whitted Amazing news!
Like · Reply · March 12 at 9:52am


Katrina Shipman
Like · Reply · March 13 at 3:49am


Trent Wamp YES YES YES!
Like · Reply · March 12 at 1:15pm

SUPPLEMENTAL #2
March 28, 2016
11:49 am

WRCB Channel 3 Eyewitness News
March 12 at 4:38pm ·

$25M behavioral health hospital proposed for Chattanooga

Read more at: http://www.wrcbtv.com/.../25m-behavioral-health-hospital-prop...

Like **Comment** **Share**

266 Top Comments

77 shares

Write a comment...

Gary Starnes This is badly needed in this area to treat patients with mental illnesses. It will be particularly helpful to our criminal justice system that is currently overwhelmed with folks charged with crimes who have mental illnesses. For example, 46% of those currently in jail have mental illnesses and it costs approximately $250,000 per year to give them badly needed medication. Our recently implemented mental health court has been very successful but beds, inpatient treatment, and additional mental health professionals will be very welcome. Thank you Erlanger.

Like · Reply · 18 · March 12 at 8:03pm

Jodi Renfro What are the staistics on the ones who are in jail that have been diagnosed outside of jail that are currently not being adequately treated in jail?

Like · Reply · 1 · March 12 at 9:05pm · Edited

Gary Starnes I'm not sure about those stats. But let me give you another staggering number. A few short years ago, the legislature and/ governor (I believe the Bredesen administration) closed several mental health facilities up and down east Tennessee to "save money." What happened next? They were all sent to Moccasin Bend Mental Health (MBMH). Currently, 54 of 95 counties are sending mental health patients to MBMH with "zero" additional funding and no upgrades to MBMH which was built in the late 70s. This has overwhelmed MBMH and Hamilton County. This is astounding to say the least.

Like · Reply · 3 · March 12 at 9:39pm

Jodi Renfro I agree Judge Starnes it is astounding. But there are so many more currently incarcerated who are not getting the help they require. I have a son at Silverdale that was diagnosed as high

SUPPLEMENTAL #2
March 28, 2016
11:49 am

functioning autism and drepression who only gets his meds when medical decides to have med call. A public defender who isn't worth a crap and a prosecutor who, well I cant say what she is. I have called Silverdale and the excuse I get is they are severely understaffed. I have asked the PD to help and I get the same excuse. Sorry I brought up my families personal experience but I also wanted to show the lack of help available to inmates as well.

Like · Reply · 1 · March 13 at 3:02pm

Stephanie Coley Villalba It's a revolving door. Lack of mental healthcare facilities leads to more inmates in jails and prisons where they get no care etc. If the one is taken care of and there are more facilities and funding then it should free up a lot of over populating in the jail systems.

Like · Reply · March 13 at 4:07pm

Gary Starnes Ms. Renfro, if you will send me a private message with your contact number, I will check on your son on Monday. Thanks.

Like · Reply · 1 · March 13 at 5:57pm

Kristy Brooks Posey There's also many living on the streets. That administration that chose to "save money" must be very uneducated and have no loved ones with mental health issues!

Like · Reply · 1 · March 13 at 6:24pm

Write a reply...

Diane Whited I hope they keep it clean..that is absolutely the dirtiest place ever. And u can forget about asking 4 anything. Took hour 2 get my mom pain meds..

Like · Reply · 4 · March 12 at 6:31pm

Wendy Grider I know. Last time I was there empty Coke can in what I call cubicle rooms where they saw patients since ER was running over. Time before last in ER went in with foot injury & left with flu since they didn't enforce mask rules

Like · Reply · 1 · March 12 at 9:13pm

Write a reply...

Cheryl Lynn Curtis I think if we are truthful with ourselves, we can see state and federal dollars coming down the pipeline for opioid addiction treatment. Reimbursements in that particular area of mental health will be plentiful so Erlanger stands to generate substantial revenue. I don't fault them for that; I am "just saying" that they know between that funding and some monies coming due to mental health issues with mass shootings, there will be funds available to pay for treatment. If there had been money to be made before now, they would have already been on the bandwagon. Whatever the motivation, I am pleased to see some treatment options coming to the area to take the pressure off the Emergency Room and the state run facilities. It's long overdue.

Like · Reply · 1 · March 13 at 12:33am

Katie Hurst Ummm they aren't talking about expanding the hospital already there. This is for mental health ONLY!

Like · Reply · 2 · March 12 at 6:36pm

Bill Trewhitt We are lucky to have a hospital like Erlanger here.

Like · Reply · 13 · March 12 at 4:48pm

Kimberly Collier They killed my dad!!!!!! They need to evaluate their own mental health better yet hired experience surgeons.

Like · Reply · March 12 at 9:18pm

Vickie Steele I hope it's better than the Hosp. for sure.. I could have died up there.. such a non caring bunch!! I went by Ambulance & all they did was check my heart.. My BP was crazy & worst of all I was having Muscle spasms all over my body_Shaking- They gave me a muscle relaxer & sent me home.. Finally went to Park Ridge-They kept me for 2 Days until my Potassium was great..

Like · Reply · 5 · March 12 at 4:50pm

SUPPLEMENTAL #1

March 28, 2016
11:49 am

Katie Hurst That's why I request to be taken to Erlanger East or Parkridge East
Like · Reply · March 12 at 8:37pm · Edited

Karen Polcen I have had more problems with Erlanger & NEVER had a problem at Partridge Memorial.
Like · Reply · 1 · March 13 at 2:05pm

Write a reply...

Amy Dyer McCullough That's so right the world we Live in today puts alot of pressure on people causing mental problems. I had my daughter there and they treated me alright. Been a long time ago...
Like · Reply · 1 · March 12 at 5:06pm

Kellye Workman Stanley There cannot be enough mental health facilities in America.....let's think about the mass murders that occur that could possibly be prevented with proper treatment.
Like · Reply · 1 · March 12 at 9:26pm

Sharon Scarbrough Merrill We have 2 places, plus Geriatric mental health at Erlanger North.
Like · Reply · 1 · March 12 at 7:25pm

Wendy Grider Chattanooga already has Valley, Joe Johnson, & Moccasin Bend so why not bring some clinic that is needed in such as a cochlear clinic?
Like · Reply · 1 · March 12 at 8:28pm

Jodi Renfro Valley is a joke. If you have insurance joe Johnson is not an option. Moccassin Bend is for more criminal and severe mental health.
Like · Reply · 2 · March 12 at 9:08pm

Elicia Tallant Valley only takes people with insurance, moccasin bend only takes people who are committed by a dr, no voluntary... The wait times in ERs for a bed at Valley, MBMH, Valley West, pine ridge and Memphis is easily 60+ hours- that's 60 hours of a person in seclusion locked in a room bc there are no mental health beds available. This area does need another mental health facility- terribly
Like · Reply · 1 · March 13 at 12:25am

Wendy Grider Elicia Tallant we also need a cochlear clinic. Maybe you'd like to have to drive over 2 hrs each way for 1 appointment & have to buy gas & eat atleast 2 meals out. Another thing on days when patients have back to back appt's say 1 on Tuesday & 1 on Wednesday try over $100 for hotel room close to Vanderbilt since insurance won't cover that.
Like · Reply · March 13 at 9:22am

Write a reply...

Jaime Sanders This is so needed in our community! What a great resource it would be for so many who have minimal if any treatment options.
Like · Reply · 1 · March 12 at 6:28pm

Gretchen Gurley So many suffer from mental illness this will be great.
Like · Reply · 4 · March 12 at 4:53pm

Charlie Bradbury Great news! I don't like the location of erlanger's main campus, but this is still a needed facility.
Like · Reply · March 13 at 9:39am

Jodi Renfro Moccassin Bend is for more criminal or severely mental disabilities. I hope this goes thru. Parkridge Valley is horrible.
Like · Reply · 3 · March 12 at 5:16pm

Chris Limburg Thank you...you answered my question.
Like · Reply · 1 · March 12 at 8:05pm

SUPPLEMENTAL #1
March 28, 2016
11:49 am

Katie Hurst I'll be taking my son to it if they do therapy and med management. Rhea Mental Health is just not a place for kids therapy.
Like · Reply · March 12 at 8:38pm

Tabitha Sanders Katie Hurst Generations Mental Health Center across from McDonalds does therapy and med management in Rhea County
Like · Reply · March 12 at 8:44pm

Katie Hurst Thank you Tabitha Sanders. Rhea mental Health won't listen to me at all about my son. They gave him meds for something he didn't even have.
Like · Reply · March 13 at 9:30am

Write a reply...

Jessica Qualls This is has been needed for a long time. Mental healthcare in our area is in sad shape.
Like · Reply · 2 · March 12 at 5:40pm

Stephanie Coley Villalba Yes luv
Like · Reply · 1 · March 13 at 2:25pm

Write a reply...

Beverly Cooper I think they should, not enough coverage for those with behavioral problems in this area.
Like · Reply · 1 · March 13 at 8:24am

Alisha Michelle Chavez Erlanger is packed full of psych patients and they absolutely need this!
Like · Reply · 3 · March 12 at 5:37pm

Stacey Nicole Alvey I think this is the best idea I've heard in a long time!
Like · Reply · 2 · March 12 at 7:26pm

Melissa Wilbanks Bearden Mental health has sadly become a joke in our society. I'm super excited to see this happen.
Like · Reply · 1 · March 13 at 1:30pm

John-Christy Carroll-Southerland Melissa Boyd thought you think this was interesting.
Like · Reply · 1 · March 13 at 9:47am

Melissa Boyd Hopefully I will be finished with practitioners program by the time it is up and running.
Like · Reply · 1 · March 13 at 5:04pm

Write a reply...

Carol Garth Hixson This is a greatly needed facility. Beyond needed. Thank you.
Like · Reply · March 12 at 11:29pm

Melba Mitchell THE NEED IS IN CHICAGO !
Like · Reply · 1 · March 12 at 6:24pm

Chris Limburg Dont think there's much hope there...
Like · Reply · March 12 at 8:06pm

Write a reply...

Christopher Shawn Miller What about moccasin bend?
Like · Reply · 1 · March 12 at 5:09pm

Stephanie Coley Villalba More needs to be done than just the bend.

SUPPLEMENTAL #2
March 28, 2016
11:49 am

Description	Section / Item
Letter Of Accreditation – *Joint Commission*	C-II-1

The Joint Commission

SUPPLEMENTAL #2
March 28, 2016
11:49 am

July 8, 2014

Re: #7809
CCN: #440104
Program: Hospital
Accreditation Expiration Date: April 05, 2017

Kevin M. Spiegel
President and CEO
Erlanger Health System
975 East Third Street
Chattanooga, Tennessee 37403

Dear Mr. Spiegel:

This letter confirms that your March 31, 2014 - April 04, 2014 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on June 20, 2014 and June 27, 2014 and the successful on-site Medicare Deficiency Follow-up event conducted on May 19, 2014, the areas of deficiency listed below have been removed. The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of April 05, 2014. We congratulate you on your effective resolution of these deficiencies.

§482.12 Governing Body
§482.41 Physical Environment
§482.42 Infection Control

The Joint Commission is also recommending your organization for continued Medicare certification effective April 05, 2014. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following locations:

Academic Internal Medicine and Endocrinology
979 E. Third Street, Suite B-601, Chattanooga, TN, 37403

Academic Gastroenterology
979 East Third Street, Suite C-825, Chattanooga, TN, 37403

Academic Urologist at Erlanger
979 East Third Street, Suite C-535, Chattanooga, TN, 37403

The Joint Commission

SUPPLEMENTAL #2

March 28, 2016
11:49 am

Alton Park (Southside) Community Health Center
100 East 37th Street, Chattanooga, TN, 37410

Dodson Avenue Community Health Center
1200 Dodson Avenue, Chattanooga, TN, 37406

Erlanger Academic Urologists
1755 Gunbarrel Road, Suite 209, Chattanooga, TN, 37421

Erlanger at Volkswagon Drive Wellness Center
7380 Volkswagon Drive, Suite 110, Chattanooga, TN, 37416

Erlanger East Family Practice
1755 Gunbarrel Road, Suite 201, Chattanooga, TN, 37421

Erlanger East Imaging
1751 Gunbarrel Road, Chattanooga, TN, 37421

Erlanger Health System - East Campus
1751 Gunbarrel Road, Chattanooga, TN, 37421

Erlanger Health System - Main Site
975 East Third Street, Chattanooga, TN, 37403

Erlanger Health System - North Campus
632 Morrison Springs Road, Chattanooga, TN, 37415

Erlanger Hypertension Management Center
979 East Third Street, Suite B601, Chattanooga, TN, 37403

Erlanger Metabolic and Bariatric Surgery Center
979 E. Third Street Suite C-620, Chattanooga, TN, 37403

Erlanger Neurology/Southeast Regional Stroke Center
979 East Third Street, Suite C830, Chattanooga, TN, 37403

Erlanger North Family Practice, Neurobehavioral & Memory Svs
632 Morrison Springs Road, Suite 202, Chattanooga, TN, 37415

Erlanger North Sleep Medicine and Neurology
632 Morrison Springs Road, Suite 300, Chattanooga, TN, 37415

Erlanger South Family Practice
60 Erlanger Drive, Suite A, Ringgold, GA, 30736

The Joint Commission

SUPPLEMENTAL #1

March 28, 2016
11:49 am

Erlanger Specialty Care for OB and Peds
1504 North Thornton Avenue, Suite 104, Dalton, GA, 30720

Hypertension Management - Chattanooga Lifestyle Center
325 Market Street, Suite 200, Chattanooga, TN, 37401

Life Style Center - Cardiac Rehab
325 Market Street, Chattanooga, TN, 37401

Ortho South
979 East Third Street suite C-430, Chattanooga, TN, 37403

Southern Orthopaedic Trauma Surgeons
979 East Third Street Suite C-225, Chattanooga, TN, 37403

TCT Cardiology/GI/Genetics
910 Blackford Street - 3rd Fl Massoud, Chattanooga, TN, 37403

TCT Children's Subspecialty Center
2700 West Side Drive, Cleveland, TN, 37312

TCT Endocrine
910 Blackford, 1st fl Massoud, Chattanooga, TN, 37403

TCT Hematology/Oncology
910 Blackford Street - 5th fl Massoud Bl, Chattanooga, TN, 37403

TCT Nephrology
910 Blackford St, Ground Level, TCTCH, Chattanooga, TN, 37403

University Health Obstetrics & Gynecology
979 East Third Street, Suite C-725, Chattanooga, TN, 37403

University Medical Assoc
960 East Third Street, Whitehall Building, Suite 208, Chattanooga, TN, 37403

University Orthopedics
979 East Third Street, Suite C-220, Chattanooga, TN, 37403

University Pediatrics
910 Blackford Street - Gr floor Massoud, Chattanooga, TN, 37403

University Pulmonary and Critical Care
979 East Third Street, Suite C 735, Chattanooga, TN, 37403

The Joint Commission

SUPPLEMENTAL #1

March 28, 2016
11:49 am

University Rheumatology Associates
979 East Third Street, Suite B-805, Chattanooga, TN, 37403

UT Dermatology
979 East Third Street, - Suite 425 A - Med Mall, Chattanooga, TN, 37403

UT Erlanger Cardiology
975 East Third Street, Suite C-520, Chattanooga, TN, 37403

UT Erlanger Cardiology East
1614 Gunbarrel Road, Ste 101, Chattanooga, TN, 37421

Ut Erlanger Health & Wellness@Signal Mtn
2600 Taft Highway, Signal Mountain, TN, 37377

UT Erlanger Lookout Mtn Primary Care
100 McFarland Road, Lookout Mountain, GA, 30750

UT Erlanger Primary and Athletic Health
1200 Pineville Road, Chattanooga, TN, 37405

UT Family Practice
1100 East Third Street, Chattanooga, TN, 37403

Workforce at UT Family Practice
1100 East 3rd Street, Chattanooga, TN, 37403

We direct your attention to some important Joint Commission policies. First, your Medicare report is publicly accessible as required by the Joint Commission's agreement with the Centers for Medicare and Medicaid Services. Second, Joint Commission policy requires that you inform us of any changes in the name or ownership of your organization, or health care services you provide.

Sincerely,

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 4/Survey and Certification Staff

SUPPLEMENTAL #1
March 28, 2016
11:49 am

Description	Section / Item
CON Replacement Pages	

As the 7th largest public health system in the nation, and the healthcare safety net for the region, *Erlanger Health System* is already the defacto provider of behavioral health services for those in need, serving those who are unable to access care elsewhere. Also, patients with cancer, cardiac or other complex medical conditions will benefit greatly from the provision of behavioral medicine provided on an outpatient basis. Having a "system of care" available to meet the needs of area residents is paramount.

The bed need calculation is derived from the current standard of thirty (30) beds per 100,000 population in the defined service area, less the current bed supply, to arrive at the "net need" for new beds in the service area. The 2016 total population is 1,571,392; therefore, the bed requirement is 471 (15.71 x 30), less the current bed supply of 402, yielding a net need for new inpatient psychiatric beds of 69.

SUPPLEMENTAL #2

March 28, 2016

11:49 am

Psychiatric Beds - Current Supply -- Primary, Secondary & Tertiary Service Areas

	Total Psych / SA Beds	== Total Psych / Substance Beds For Service Area == Child & Youth Beds	Adult Psych Beds	Geriatric Beds	Substance Abuse Beds	Total Beds
Parkridge Valley Hospital - Chattanooga, TN	172	108	32	16	16	172
Erlanger North Hospital - Chattanooga, TN	12			12		12
Parkridge West Hospital - Jasper, TN	20		20			20
Parkridge West Hospital - Jasper, TN	150		150			150
Skyridge Medical Center - Westside - Cleveland, TN	29		29			29
Southern Tenn Med Ctr - Winchester, TN	12		12			12
Hamilton Medical Center - Dalton, GA	7		7			7
Total	402	108	250	28	16	402

(*) Bed data obtained from 2014 Tennessee *Joint Annual Reports*, *Certificate Of Need* applications, and other data sources.

	==== Pop. Est. 2016 ==== Tenn.	Non-Tenn.	== Pop. Est. 2021 === Tenn.	Non-Tenn.
Child (Age 0-14)	172,951	111,190	171,916	105,829
Adolescent (Age 15-17)	36,625	23,949	41,512	28,485
Adult (Age 18-64)	593,364	345,781	595,768	342,686
Geriatric (Age 65+)	189,726	97,806	219,645	111,282
	992,666	578,726	1,028,841	588,282

Total Est. Psychiatric Bed Need - 2016	471
Total Est. Psychiatric Bed Need - 2021	485

	Est. Requirement	Current Supply	Est. Need	Proposed Bed Mix
Child / Adolescent Beds - Est. Need - 2016	103	108	-5	18
Adult Beds - Est. Need - 2016	282	266	16	46
Geriatric Beds - Est. Need - 2016	86	28	58	24
Total	471	402	69	88

(**) Substance Abuse hospital beds included in Psychiatric beds.

Please note that *Moccasin Bend Mental Health Institute* ("*MBMHI*") with 150 psychiatric beds indicates on it's website, that it does "typically" serve those which this project seeks to serve …

> "*MBMHI* assists patients who are not typically served by the private service sector and have no other inpatient treatment resources available to them."

Therefore, if *MBMHI* were not included in the current bed supply, the bed need would be 219 beds, instead of the 69 beds shown above.

There are currently a total of five (5) provider organizations delivering inpatient psychiatric and substance abuse/chemical dependency services at a total of seven (7) locations within the defined service area, for a total of 252 licensed inpatient beds.

Erlanger Behavioral Health will have a bed mix of twenty-four (24) Adult Psychiatric, twenty-four (24) Geriatric Psychiatric, eighteen (18) Child/Adolescent Psychiatric and twenty-two (22) Adult Chemical Dependency beds.

Erlanger Behavioral Health seeks to add seventy-six (76) new beds to the service area. *Erlanger North Hospital* will transfer it's current complement of twelve (12) licensed geriatric psychiatric beds to *Erlanger Behavioral Health* with approval and implementation of this CON application. This will be a total of eighty-eight (88) beds.

In a press release on January 28, 2016, U.S. Senator Lamar Alexander said that public legislative hearings on the mental health crisis in America are a "priority". As evidence, Sen. Alexander cited a 2014 national study by the *Substance Abuse & Mental Health Services Administration* which found that 1 in 5 adults had a mental health condition and 9.8 million adults had serious mental illness, such as schizophrenia, bipolar disorder or depression. Of these, nearly 60% of adults with mental illness did not receive care in 2014. Only about half of adolescents with a mental health condition received treatment. Further, in a study from 2010 - 2012, nearly 21% of adults in Tennessee reported having a mental illness.

In short, there is a critical need for additional inpatient psychiatric beds from the community need perspective, as well as *Erlanger's* institutional need perspective.

2. For adult programs, the age group of 18 years

As stated in response to item B-2, *Erlanger Behavioral Health* will accept voluntary patients, as well as involuntary patients from the judicial system. Acute mental health patients will be served at this facility, not long-term patients on a residential basis.

1. **The degree of projected financial participation in the Medicare and TennCare programs should be considered.**

Response

As stated in response to item B-2, *Erlanger Behavioral Health* will participate in both the Medicare and TennCare programs.

D. Relationship To Existing Similar Services In The Area

1. **The area's trends in occupancy and utilization of similar services should be considered.**

Response

The utilization trend for psychiatric and substance abuse beds is presented below. Utilization for CY 2014 suggests that not all populations including special needs, are receiving these necessary services. As may be seen from the data presented, *MBMHI* is operating at 91.1% occupancy in CY 2014. For this reason, it is not anticipated that the proposed project would have any impact on *MBMHI*.

SUPPLEMENTAL #1
March 28, 2016
11:49 am

Psychiatric Beds - Utilization Trend

	% Change 2011-2014	Actual Discharges 2014	2013	2012	2011
Parkridge Valley Adult - Chattanooga, TN	100.0%	2,070	-	-	-
Parkridge Valley Child/Adolescent - Chattanooga, TN	-61.0%	1,211	3,004	3,073	3,106
Parkridge Medical Center - Chattanooga, TN	-100.0%	-	-	258	291
Erlanger North Hospital - Chattanooga, TN	367.9%	262	281	268	56
Moccasin Bend MHI - Chattanooga, TN	40.3%	2,999	2,768	2,340	2,138
Parkridge West Hospital - Jasper, TN	204.9%	497	465	473	163
Skyridge Medical Center - Westside - Cleveland, TN	-0.4%	840	928	959	843
Southern Tenn Med Ctr - Winchester, TN	16.4%	170	86	135	146
Total	19.4%	8,049	7,532	7,506	6,743

	Total Psych / SA Beds	Annual Pt. Days Available		Actual Patient Days 2014	2013	2012	2011
Parkridge Valley Adult - Chattanooga, TN	64	23,360	100.0%	12,420	-	-	-
Parkridge Valley Child/Adolescent - Chattanooga, TN	108	39,420	-22.6%	30,203	44,968	39,153	39,012
Parkridge Medical Center - Chattanooga, TN	11	4,015	-100.0%	-	-	2,793	3,054
Erlanger North Hospital - Chattanooga, TN	12	4,380	-1.7%	3,628	3,761	3,746	3,692
Moccasin Bend MHI - Chattanooga, TN	150	54,750	34.6%	49,875	47,908	37,970	37,055
Parkridge West Hospital - Jasper, TN	20	7,300	222.9%	4,930	5,055	5,278	1,527
Skyridge Medical Center - Westside - Cleveland, TN	29	10,585	40.6%	2,203	1,038	1,362	1,567
Southern Tenn Med Ctr - Winchester, TN	12	4,380	-6.3%	4,170	3,916	4,421	4,448
Total	406	148,190	18.9%	107,429	106,646	94,723	90,355

	Occupancy Rate 2014	2013	2012	2012
Parkridge Valley Adult - Chattanooga, TN	100.0%	53.2%	-	-
Parkridge Valley Child/Adolescent - Chattanooga, TN	-22.6%	76.6%	114.1%	99.3%
Parkridge Medical Center - Chattanooga, TN	-100.0%	-	-	69.6%
Erlanger North Hospital - Chattanooga, TN	-1.8%	82.8%	85.9%	85.5%
Moccasin Bend MHI - Chattanooga, TN	34.6%	91.1%	87.5%	69.4%
Parkridge West Hospital - Jasper, TN	223.0%	67.5%	69.2%	72.3%
Skyridge Medical Center - Westside - Cleveland, TN	40.5%	20.8%	9.8%	12.9%
Southern Tenn Med Ctr - Winchester, TN	-6.3%	95.2%	89.4%	100.9%
Total	18.9%	72.5%	72.0%	63.9%

NOTES
(1) Utilization data obtained from Tennessee *Joint Annual Reports*.
(2) Parkridge Valley moved it's Adult & Geriatric beds to a new campus in 2014.
(3) Utilization data not available for Hamilton Medical Center in Dalton, Georgia.

Nationally, utilization of Psychiatric services is expected to increase over the next ten (10) years between 2015 and 2025, with overall growth for inpatient service at a rate of 5% and overall growth for outpatient service at a rate of 19%. Sg2, a national healthcare consultancy firm, provides the following detail by growth factor:

Factor	Inpatient	Outpatient
Population	7%	8%
Epidemiology	1%	3%
Economy	.5%	1%
Policy	.2%	1%
Innovation & Tech.	-2%	1%

SUPPLEMENTAL #1

March 28, 2016
11:49 am

Psychiatric Beds - Utilization Trend

	% Change 2011-2014	Actual Discharges 2014	2013	2012	2011
Parkridge Valley Adult - Chattanooga, TN	100.0%	2,070	-	-	-
Parkridge Valley Child/Adolescent - Chattanooga, TN	-61.0%	1,211	3,004	3,073	3,106
Parkridge Medical Center - Chattanooga, TN	-100.0%	-	-	258	291
Erlanger North Hospital - Chattanooga, TN	367.9%	262	281	268	56
Moccasin Bend MHI - Chattanooga, TN	40.3%	2,999	2,768	2,340	2,138
Parkridge West Hospital - Jasper, TN	204.9%	497	465	473	163
Skyridge Medical Center - Westside - Cleveland, TN	-0.4%	840	928	959	843
Southern Tenn Med Ctr - Winchester, TN	16.4%	170	86	135	146
Total	19.4%	8,049	7,532	7,506	6,743

	Total Psych / SA Beds	Annual Pt. Days Available		Actual Patient Days 2014	2013	2012	2011
Parkridge Valley Adult - Chattanooga, TN	64	23,360	100.0%	12,420	-	-	-
Parkridge Valley Child/Adolescent - Chattanooga, TN	108	39,420	-22.6%	30,203	44,968	39,153	39,012
Parkridge Medical Center - Chattanooga, TN	11	4,015	-100.0%	-	-	2,793	3,054
Erlanger North Hospital - Chattanooga, TN	12	4,380	-1.7%	3,628	3,761	3,746	3,692
Moccasin Bend MHI - Chattanooga, TN	150	54,750	34.6%	49,875	47,908	37,970	37,055
Parkridge West Hospital - Jasper, TN	20	7,300	222.9%	4,930	5,055	5,278	1,527
Skyridge Medical Center - Westside - Cleveland, TN	29	10,585	40.6%	2,203	1,038	1,362	1,567
Southern Tenn Med Ctr - Winchester, TN	12	4,380	-6.3%	4,170	3,916	4,421	4,448
Total	406	148,190	18.9%	107,429	106,646	94,723	90,355

	Occupancy Rate 2014	2013	2012	2012
Parkridge Valley Adult - Chattanooga, TN	100.0%	53.2%	-	-	-
Parkridge Valley Child/Adolescent - Chattanooga, TN	-22.6%	76.6%	114.1%	99.3%	99.0%
Parkridge Medical Center - Chattanooga, TN	-100.0%	-	-	69.6%	76.1%
Erlanger North Hospital - Chattanooga, TN	-1.8%	82.8%	85.9%	85.5%	84.3%
Moccasin Bend MHI - Chattanooga, TN	34.6%	91.1%	87.5%	69.4%	67.7%
Parkridge West Hospital - Jasper, TN	223.0%	67.5%	69.2%	72.3%	20.9%
Skyridge Medical Center - Westside - Cleveland, TN	40.5%	20.8%	9.8%	12.9%	14.8%
Southern Tenn Med Ctr - Winchester, TN	-6.3%	95.2%	89.4%	100.9%	101.6%
Total	18.9%	72.5%	72.0%	63.9%	61.0%

NOTES
(1) Utilization data obtained from Tennessee *Joint Annual Reports*.
(2) Parkridge Valley moved it's Adult & Geriatric beds to a new campus in 2014.
(3) Utilization data not available for Hamilton Medical Center in Dalton, Georgia.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.

SUPPLEMENTAL #1
March 28, 2016
11:49 am

PROJECT COST CHART

A.	Construction And Equipment Acquired By Purchase.		
	1.	Architecural And Engineering Fees	1,632,600
	2.	Legal, Administrative, Consultant Fees (Excluding CON Filing Fees)	50,000
	3.	Acquisition Of Site	825,000
	4.	Preparation Of Site	1,800,000
	5.	Construction Costs	18,720,000
	6.	Contingency Fund	1,000,000
	7.	Fixed Equipment (Not Included In Construction Contract)	350,000
	8.	Moveable Equipment (List all equipment over $ 50,000)	
	9.	Other (Specify) Dietary equipment & misc. start-up costs.	690,000
B.	Acquisition By Gift, Donation, Or Lease.		
	1.	Facility (inclusive of building and land)	0
	2.	Building Only	0
	3.	Land Only	0
	4.	Equipment (Specify) _____	0
	5.	Other (Specify) _____	0
C.	Financing Costs And Fees.		
	1.	Interim Financing	0
	2.	Underwriting Costs	0
	3.	Reserve For One Year's Debt Service	0
	4.	Other (Specify) _____	0
D.	Estimated Project Cost	(A + B + C)	25,067,600
E.	CON Filing Fee		45,000
F.	Total Estimated Project Cost	(D + E)	25,112,600

SUPPLEMENTAL #1
March 28, 2016
11:49 am

PROJECTED DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July (Month).

		Year 1	Year 2
A.	Utilization Data (Specify Unit Of Measure) Pt. Days	8,798	17,481
B.	Revenue From Services To Patients		
	1. Inpatient Services	11,870,450	26,516,061
	2. Outpatient Services	121,350	339,270
	3. Emergency Services	-	-
	4. Other Operating Revenue	10,000	12,000
	Gross Operating Revenue	12,001,800	26,867,331
C.	Deductions From Operating Revenue		
	1. Contractual Adjustments	6,727,381	15,027,536
	2. Provision For Charity Care		
	3. Provision For Bad Debt	603,442	887,985
	Total Deductions	7,330,823	15,915,521
	NET OPERATING REVENUE	4,670,977	10,951,810
D.	Operating Expenses		
	1. Salaries And Wages	3,432,825	6,124,604
	2. Physician's Salaries And Wages	172,335	314,512
	3. Supplies	319,545	483,451
	4. Taxes		
	5. Depreciation	812,831	841,574
	6. Rent	24,000	24,720
	7. Interest - Other Than Capital		
	8. Management Fees:		
	a. Fees To Affiliates	93,419	219,036
	b. Fees To Non-Affiliates		
	9. Other Expenses	1,027,943	2,829,476
	(Specify) Service Contracts		
	Total Operating Expenses	5,882,898	10,837,373
E.	Other Revenue (Expenses) – Net		
	(Specify)		
	NET OPERATING INCOME (LOSS)	(1,211,921)	114,438
F.	Capital Expenditures		
	1. Retirement Of Principal		
	2. Interest		
	Total Capital Expenditures		
	NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	(1,211,921)	114,438

SUPPLEMENTAL #1
March 28, 2016
11:49 am

Description	Section / Item
Acadia SEC Form 10-K	C-III-10

SUPPLEMENTAL #1
March 28, 2016
11:49 am

Table of Contents

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

(Mark One)
☒ ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2015

or

☐ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from _____ to _____

Commission File Number: 001-35331

ACADIA HEALTHCARE COMPANY, INC.
(Exact Name of Registrant as Specified in Its Charter)

Delaware	45-2492228
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

6100 Tower Circle, Suite 1000
Franklin, Tennessee 37067
(Address, including zip code, of registrant's principal executive offices)

(615) 861-6000
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of each Class	Name of exchange on which registered
Common Stock, $.01 par value	NASDAQ Global Select Market

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

As of June 30, 2015, the aggregate market value of the shares of common stock of the registrant held by non-affiliates was approximately $4.0 billion, based on the closing price of the registrant's common stock reported on the NASDAQ Global Select Market of $78.33 per share.

As of February 25, 2016, there were 87,219,536 shares of the registrant's common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's definitive proxy statement for its 2016 annual meeting of stockholders to be held on May 19, 2016 are incorporated by reference into Part III of this Form 10-K.

ACADIA HEALTHCARE COMPANY, INC.
ANNUAL REPORT ON FORM 10-K
TABLE OF CONTENTS

PART I

Unless the context otherwise requires, all references in this Annual Report on Form 10-K to "Acadia," "the Company," "we," "us" or "our" mean Acadia Healthcare Company, Inc. and its consolidated subsidiaries.

Item 1. Business.

Overview

Our business strategy is to acquire and develop behavioral healthcare facilities and improve our operating results within our facilities and our other behavioral healthcare operations. We strive to improve the operating results of our facilities by providing high-quality services, expanding referral networks and marketing initiatives while meeting the increased demand for behavioral healthcare services through expansion of our current locations as well as developing new services within existing locations. At December 31, 2015, we operated 258 behavioral healthcare facilities with over 9,900 beds in 39 states, the United Kingdom and Puerto Rico. During the year ended December 31, 2015, we acquired 176 facilities with approximately 3,450 beds and added 670 new beds, including 460 to existing facilities and 210 in two de novo facilities. On February 16, 2016, we completed the acquisition of Priory Group No. 1 Limited ("Priory") which operated 327 facilities with approximately 7,100 beds at December 31, 2015. For the year ending December 31, 2016, we expect to add approximately 800 total beds exclusive of acquisitions.

We are the leading publicly traded pure-play provider of behavioral healthcare services, with operations in the United States and the United Kingdom. Management believes that the Company's recent acquisitions position the Company as a leading platform in a highly fragmented industry under the direction of an experienced management team that has significant industry expertise. Management expects to take advantage of several strategies that are more accessible as a result of our increased size and geographic scale, including continuing a national marketing strategy to attract new patients and referral sources, increasing our volume of out-of-state referrals, providing a broader range of services to new and existing patients and clients and selectively pursuing opportunities to expand our facility and bed count.

Acadia was formed as a limited liability company in the State of Delaware in 2005, and converted to a corporation on May 13, 2011. Our common stock is listed for trading on The NASDAQ Global Select Market under the symbol "ACHC." Our principal executive offices are located at 6100 Tower Circle, Suite 1000, Franklin, Tennessee 37067, and our telephone number is (615) 861-6000.

Acquisitions

On February 16, 2016, we completed the acquisition of Priory for a total purchase price of approximately $2.2 billion, including total cash consideration of approximately $1.9 billion and the issuance of 4,033,561 shares of our common stock. Priory is the leading independent provider of behavioral healthcare services in the United Kingdom.

On December 1, 2015, we completed the acquisition of certain facilities from MMO Behavioral Health Systems ("MMO"), including two acute inpatient behavioral health facilities with a total of 80 beds located in Jennings and Covington, Louisiana, for cash consideration of approximately $20.2 million.

On November 1, 2015, we completed the acquisitions of (i) Discovery House-Group, Inc. ("Discovery House") for cash consideration of approximately $118.5 million, (ii) Duffy's Napa Valley Rehab ("Duffy's") for cash consideration of approximately $29.6 million and (iii) Cleveland House for approximately $10.3 million. Discovery House operates 19 comprehensive treatment centers located in four states. Duffy's is a substance abuse facility with 61 beds located in Calistoga, California. Cleveland House is an inpatient psychiatric facility with 32 beds located in England.

On October 1, 2015, we completed the acquisition of Meadow View ("Meadow View"), an inpatient psychiatric facility with 28 beds located in England, for cash consideration of approximately $6.8 million.

On September 1, 2015, we completed the acquisitions of (i) three facilities from The Danshell Group ("Danshell") for approximately $59.8 million, (ii) two facilities from Health and Social Care Partnerships ("H&SCP") for approximately $26.2 million and (iii) Manor Hall ("Manor Hall") for approximately $14.0 million. The inpatient psychiatric facilities acquired from Danshell have an aggregate of 73 beds and are located in England. The inpatient psychiatric facilities acquired from H&SCP have an aggregate of 50 beds and are located in England. Manor Hall has 26 beds and is located in England.

On August 31, 2015, we completed the acquisition of a controlling interest in Southcoast Behavioral ("Southcoast"), an inpatient psychiatric facility located in Fairhaven, Massachusetts. We own 75% of the equity interests in the facility.

On July 1, 2015, we completed the acquisition of the assets of Belmont Behavioral Health ("Belmont"), an inpatient psychiatric facility with 147 beds located in Philadelphia, Pennsylvania for cash consideration of approximately $38.2 million which consists of $35.0 million base purchase price and an estimated working capital settlement of $3.2 million.

On July 1, 2015, we completed the acquisition of The Manor Clinic ("The Manor Clinic"), a substance abuse facility with 15 beds located in England, for cash consideration of approximately $5.9 million.

On June 1, 2015, we completed the acquisitions of (i) one facility from Choice for approximately $25.9 million and (ii) 15 facilities from Care UK Limited ("Care UK") for approximately $88.2 million. The inpatient psychiatric facility acquired from Choice has 42 beds and is located in England. The inpatient psychiatric facilities acquired from Care UK have an aggregate of 299 beds and are located in England.

On April 1, 2015, we completed the acquisitions of (i) two facilities from Choice Lifestyles ("Choice") for approximately $37.5 million, (ii) Pastoral Care Group ("Pastoral") for approximately $34.2 million and (iii) Mildmay Oaks f/k/a Vista Independent Hospital ("Mildmay Oaks") for approximately $14.9 million. The two inpatient psychiatric facilities acquired from Choice have an aggregate of 48 beds and are located in England. Pastoral operates two inpatient psychiatric facilities with an aggregate of 65 beds located in Wales. Mildmay Oaks is an inpatient psychiatric facility with 67 beds located in England.

On March 1, 2015, we acquired the stock of Quality Addictions Management, Inc. ("QAM") for total consideration of approximately $54.8 million. QAM operates seven comprehensive treatment centers located in Wisconsin.

On February 11, 2015, we completed the acquisition of CRC Health Group, Inc. ("CRC") for total consideration of approximately $1.3 billion. As consideration for the acquisition, we issued 5,975,326 shares of our common stock to certain holders of CRC common stock and repaid CRC's outstanding indebtedness. CRC is a leading provider of treatment services related to substance abuse and other addiction and behavioral disorders. CRC operated 35 inpatient facilities with over 2,400 beds and 81 comprehensive treatment centers located in 30 states at the acquisition date.

On December 31, 2014, we completed the acquisition of Skyway House ("Skyway"), a substance abuse facility with 28 beds located in Chico, California, for cash consideration of $0.3 million. On December 1, 2014, we acquired the assets of Croxton Warwick Lodge ("Croxton"), an inpatient psychiatric facility with 24 beds located in England, for cash consideration of $15.6 million. On September 3, 2014, we completed the acquisition of McCallum Place ("McCallum"), an eating disorder treatment facility with 85 beds offering residential, partial hospitalization and intensive outpatient treatment programs located in St. Louis, Missouri, and Austin, Texas, for total consideration of $37.4 million. On July 1, 2014, we acquired Partnerships in Care for cash consideration of $661.7 million, which was net of cash acquired of $12.0 million and the gain on settlement of foreign currency derivatives of $15.3 million. At the acquisition date, Partnerships in Care was the second largest independent provider of inpatient behavioral healthcare services in the United Kingdom, operating 23 inpatient behavioral healthcare facilities with over 1,200 beds. On January 1, 2014, we acquired the assets of Pacific Grove Hospital ("Pacific Grove"), an inpatient psychiatric facility with 68 beds located in Riverside, California, for cash consideration of $10.5 million.

For the years ended December 31, 2015 and 2014, we generated revenue of $1.8 billion and $1.0 billion, respectively. On a pro forma basis for the years ended December 31, 2015 and 2014, giving effect to Pacific Grove, Partnerships in Care, McCallum, Croxton, Skyway, CRC, QAM, Choice, Pastoral, Mildmay Oaks, Care UK, The Manor Clinic, Belmont, Southcoast, Danshell, H&SCP, Manor Hall, Meadow View, Cleveland House, Duffy's, Discovery House and MMO (collectively the "2014 and 2015 Acquisitions") and the acquisition of Priory described above as if such acquisitions had been completed as of January 1, 2014, we would have generated pro forma revenue of $2.9 billion and $2.7 billion, respectively. See "Pro Forma Financial Information" and "Note 4 – Acquisitions in the Consolidated Financial Statements" for additional details about pro forma information.

During 2013, we completed our acquisitions of Greenleaf Center, DMC-Memphis, Inc. d/b/a Delta Medical Center, two facilities from United Medical Corporation, The Refuge, a Healing Place, Longleaf Hospital and Cascade Behavioral Hospital.

Financing Transactions

On February 16, 2016, we issued $390.0 million of 6.500% Senior Notes due 2024 (the "6.500% Senior Notes"). The 6.500% Senior Notes mature on March 1, 2024 and bear interest at a rate of 6.500% per annum, payable semi-annually in arrears on March 1 and September 1 of each year, beginning on September 1, 2016. We used the net proceeds to fund a portion of the purchase price for the acquisition of Priory and the fees and expenses for such acquisition and the related financing transactions.

On February 16, 2016, we entered into a Second Incremental Facility Amendment (the "Second Incremental Amendment") to our Amended and Restated Credit Agreement, dated as of December 31, 2012 (the "Amended and Restated Credit Agreement"). The

Second Incremental Amendment activated a new $955.0 million incremental Term Loan B facility (the "New TLB Facility") and added $135.0 million to the Term Loan A facility (the "TLA Facility") to our Amended and Restated Senior Secured Credit Facility (the "Amended and Restated Senior Credit Facility"), subject to limited conditionality provisions. Borrowings under the New TLB Facility were used to fund a portion of the purchase price for the acquisition of Priory and the fees and expenses for such acquisition and the related financing transactions. Borrowings under the TLA Facility were used to pay down the majority of our $300.0 million revolving credit facility.

On January 25, 2016, we entered into the Ninth Amendment (the "Ninth Amendment") to the Amended and Restated Senior Credit Facility. The Ninth Amendment modifies certain definitions and provides increased flexibility to us in terms of our financial covenants.

On January 12, 2016, we completed the offering of 11,500,000 shares of common stock (including shares sold pursuant to the exercise of the over-allotment option that we granted to the underwriters as part of the offering) at a public offering price of $61.00 per share. The net proceeds to us from the sale of the shares, after deducting the underwriting discount of $15.8 million and additional offering related costs of $0.7 million, were approximately $685.0 million. We used the net offering proceeds to fund a portion of the purchase price for the acquisition of Priory.

On September 21, 2015, we issued $275.0 million of additional 5.625% Senior Notes due 2033 (the "5.625% Senior Notes"). The additional notes form a single class of debt securities with the existing 5.625% Senior Notes. Giving effect to this issuance, we have outstanding and aggregate of $650.0 million of 5.625% Senior Notes.

On September 21, 2015, we purchased approximately $88.3 million aggregate principal amount of 12.875% Senior Notes due 2018 (the "12.875% Senior Notes") in connection with a tender offer for any and all of the 12.875% Senior Notes. The notes purchased represented 90.6% of the outstanding $97.5 million principal amount of 12.875% Senior Notes. The 12.875% Senior Notes were purchased at a price of 107.875% of the principal amount thereof plus accrued and unpaid interest to, but not including, September 21, 2015. On September 18, 2015, we delivered a notice to redeem all $9.2 million in principal amount of the 12.875% Senior Notes remaining outstanding following the consummation of the tender offer. On November 1, 2015, we redeemed all of the outstanding $9.2 million principal amount of the 12.875% Senior Notes. As a result of this redemption, both the 12.875% Senior Notes and the indenture governing the 12.875% Senior Notes were satisfied and discharged in accordance with their terms. In connection with the purchase of notes, the Company recorded a debt extinguishment charge of approximately $10.8 million for the year ended December 31, 2015, including the premium and write-off of deferred financing costs, which was recorded in debt extinguishment costs in the accompanying consolidated statements of income.

On May 11, 2015, we completed the offering of 5,175,000 shares of common stock (including shares sold pursuant to the exercise of the over-allotment option that we granted to the underwriters as part of the offering) at a price of $66.50 per share. The net proceeds to us from the sale of the shares, after deducting the underwriting discount of $12.0 million and additional offering-related costs of $0.8 million, were $331.3 million. We used the net offering proceeds to repay outstanding indebtedness and fund acquisitions.

On April 22, 2015, we entered into an Eighth Amendment to our Amended and Restated Credit Agreement (the "Eighth Amendment"). The Eighth Amendment changed the definition of "Change of Control" in part to remove a provision whose purpose was, when calculating whether a majority of incumbent directors have approved new directors, that any incumbent director that became a director as a result of a threatened or actual proxy contest was not counted in such calculation.

On February 11, 2015, we issued $375.0 million of 5.625% Senior Notes. The 5.625% Senior Notes mature on February 15, 2023 and bear interest at a rate of 5.625% per annum, payable semi-annually in arrears on February 15 and August 15 of each year, beginning on August 15, 2015. We used the net proceeds to fund a portion of the consideration for the acquisition of CRC.

On February 11, 2015, we entered into a First Incremental Facility Amendment (the "First Incremental Amendment") to the Amended and Restated Credit Agreement. The First Incremental Amendment activated a new $500.0 million incremental Term Loan B facility (the "Existing TLB Facility") that was added to the Amended and Restated Senior Secured Credit Facility, subject to limited conditionality provisions. Borrowings under the Existing TLB Facility were used to fund a portion of the consideration for the acquisition of CRC.

On February 6, 2015, we entered into a Seventh Amendment (the "Seventh Amendment") to our Amended and Restated Credit Agreement. The Seventh Amendment added Citibank, N.A. as an "L/C Issuer" under the Amended and Restated Credit Agreement in order to permit the rollover of CRC's existing letters of credit into the Amended and Restated Credit Agreement and increased both the Company's Letter of Credit Sublimit and Swing Line Sublimit to $20.0 million.

On December 15, 2014, we entered into a Sixth Amendment (the "Sixth Amendment") to our Amended and Restated Credit Agreement. Pursuant to the Sixth Amendment, we incurred $235.0 million of additional term loans. A portion of the additional term

loan advance was used to prepay our outstanding revolving loans, and a portion of the additional term loan advance was held as cash on our consolidated balance sheet. The Sixth Amendment also specifically permitted the acquisition of CRC. In connection with the acquisition of CRC, the Sixth Amendment (i) imposed a temporary reserve on our revolving credit facility in the amount of $110.0 million in order to preserve such reserved amounts for later borrowings to partially fund the consideration for the acquisition of CRC (subject to limited conditionality provisions) (the reserve is no longer in effect due to the acquisition of CRC), (ii) permitted the incurrence of an additional incremental term loan facility under the Amended and Restated Credit Agreement partially to fund the consideration for the acquisition of CRC (subject to limited conditionality provisions) and (iii) permitted our issuance of additional senior unsecured indebtedness or senior unsecured bridge indebtedness partially to fund the consideration for the acquisition of CRC.

On July 1, 2014, we issued $300.0 million of 5.125% Senior Notes due 2022 (the "5.125% Senior Notes"). The 5.125% Senior Notes mature on July 1, 2022 and bear interest at a rate of 5.125% per annum, payable semi-annually in arrears on January 1 and July 1 of each year, beginning on January 1, 2015. We used the net proceeds to fund a portion of the consideration for the acquisition of Partnerships in Care.

On June 17, 2014, we completed the offering of 8,881,794 shares of common stock (including shares sold pursuant to the exercise of the over-allotment option that we granted to the underwriters as part of the offering) at a price of $44.00 per share. The net proceeds to us from the sale of the shares, after deducting the underwriting discount of $15.6 million and additional offering-related expenses of $0.8 million, were $374.4 million. We used the net offering proceeds to fund a portion of the consideration for the acquisition of Partnerships in Care.

On June 16, 2014, we entered into a Fifth Amendment (the "Fifth Amendment") to the Amended and Restated Credit Agreement. The Fifth Amendment specifically permitted our acquisition of Partnerships in Care, gave us the ability to incur a tranche of term loan B debt in the future through its incremental credit facility, and modified certain of the restrictive covenants on miscellaneous investments and incurrence of miscellaneous liens. The restrictive covenants on investments in joint ventures and foreign subsidiaries were also amended such that we may now invest, in any given fiscal year, up to five percent (5%) of its total assets in both joint ventures and foreign subsidiaries, respectively; provided that the aggregate amount of investments in both joint ventures and foreign subsidiaries, respectively, may not exceed ten percent (10%) of its total assets over the life of the Amended and Restated Senior Credit Facility; provided further that the aggregate amount of investments made in both joint ventures and foreign subsidiaries collectively pursuant to the foregoing may not exceed fifteen percent (15%) of its total assets. Finally, the Fifth Amendment provided increased flexibility to us in terms of its financial covenants.

On February 13, 2014, we entered into a Fourth Amendment (the "Fourth Amendment") to our Amended and Restated Credit Agreement, to increase the size of our Amended and Restated Senior Credit Facility and extend the maturity date thereof, which resulted in our having a revolving line of credit of up to $300.0 million and term loans of $300.0 million. The Fourth Amendment also reduced the interest rates applicable to the Amended and Restated Senior Credit Facility and provided increased flexibility to us in terms of our financial and other restrictive covenants.

On March 12, 2013, we issued $150.0 million of 6.125% Senior Notes due 2021 (the "6.125% Notes" and together with the 5.125% Senior Notes, the 5.625% Senior Notes and the 6.500% Senior Notes, the "Senior Notes"). The 6.125% Senior Notes mature on March 15, 2021 and bear interest at a rate of 6.125% per annum, payable semi-annually in arrears on March 15 and September 15 of each year, beginning on September 15, 2013.

On March 12, 2013, we redeemed $52.5 million of the 12.875% Senior Notes using a portion of the net proceeds of our December 2012 equity offering pursuant to the provision in the indenture permitting an optional redemption with equity proceeds of up to 35% of the principal amount of 12.875% Senior Notes. The 12.875% Senior Notes were redeemed at a redemption price of 112.875% of the principal amount thereof plus accrued and unpaid interest to, but not including, the redemption date in accordance with the provisions of the indenture governing the 12.875% Senior Notes. As part of the redemption of 35% of the 12.875% Senior Notes, we recorded a debt extinguishment charge of $9.4 million, including the premium and write-off of deferred financing costs, which was recorded in debt extinguishment costs in the consolidated statements of income.

On December 31, 2012, we amended and restated our existing senior secured credit agreement, to provide a revolving line of credit of $100.0 million and term loans of $300.0 million, which resulted in debt proceeds of $151.1 million. We used $151.1 million of the term loans partially to fund the acquisition of Behavioral Centers of America, LLC ("BCA") and AmiCare Behavioral Centers, LLC ("AmiCare") on December 31, 2012. The credit agreement was amended further in 2013 and 2014 as disclosed above and in our other filings with the Securities and Exchange Commission ("SEC").

On December 12, 2012, we completed the offering of 7,000,000 shares of Acadia common stock and on December 24, 2012, we completed the offering of 1,050,000 shares of Acadia common stock sold pursuant to the exercise of the over-allotment option that we granted to the underwriters as part of the offering at a price of $22.50 per share. The net proceeds to us from the sale of the shares, after deducting the underwriting discount of $6.3 million and additional offering-related expenses of $1.0 million, were $172.8 million. We used the net proceeds principally to fund the acquisitions of AmiCare and BCA on December 31, 2012.

On May 21, 2012, we completed the offering of 9,487,500 shares of Acadia common stock (including shares sold pursuant to the exercise of the over-allotment option that we granted to the underwriters as part of the offering) at a price of $15.50 per share. The net proceeds to us from the sale of the shares, after deducting the underwriting discount of $6.4 million and additional offering-related expenses of $0.7 million, were $139.0 million. We used the net offering proceeds to fund the acquisition of Timberline Knolls, LLC and acquisitions of certain facilities previously leased.

Competitive Strengths

Management believes the following strengths differentiate us from other providers of behavioral healthcare services:

Premier operational management team with track record of success. Our management team has over 185 combined years of experience in acquiring, integrating and operating a variety of behavioral health facilities. Following the sale of Psychiatric Solutions, Inc. ("PSI") to Universal Health Services, Inc. ("UHS") in November 2010, certain of PSI's key former executive officers joined Acadia in February 2011. The extensive national experience and operational expertise of our management team give us what management believes to be the premier leadership team in the behavioral healthcare industry. Our management team strives to use its years of experience operating behavioral healthcare facilities to generate strong cash flow and grow a profitable business.

Favorable industry and legislative trends. According to a 2012 survey by Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services ("SAMHSA"), 18.6% of adults in the United States aged 18 years or older suffer from a mental illness in a given year and about 4% suffer from a serious mental illness. According to the National Institute of Mental Health, over 20% of children, either currently or at some point in their life, have had a seriously debilitating mental disorder. Management believes the market for behavioral services will continue to grow due to increased awareness of mental health and substance abuse conditions and treatment options. According to a 2014 SAMHSA report, national expenditures at substance abuse treatment facilities are expected to reach $42.1 billion in 2020, up from $24.3 billion in 2009.

While the growing awareness of mental health and substance abuse conditions is expected to accelerate demand for services, recent healthcare reform in the United States is expected to increase access to industry services as more people obtain insurance coverage. A key aspect of reform legislation is the extension of mental health parity protections established into law by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the "MHPAEA"). The MHPAEA requires employers who provide behavioral health and addiction benefits to provide such coverage to the same extent as other medical conditions.

The mental health hospitals market in the United Kingdom was roughly £14.4 billion in 2011. As a result of government budget constraints and an increased focus on quality, the independent mental health hospitals market has witnessed significant expansion in the last decade, making it one of the fastest growing sectors in the United Kingdom healthcare industry. Demand for independent sector beds has grown significantly as a result of the National Health Service (the "NHS") reducing its bed capacity and increasing hospitalization rates. Independent sector demand is expected to further increase in light of additional bed closures and reduction in community capacity by the NHS.

Leading platform in attractive healthcare niche. We are a leading behavioral healthcare platform in an industry that is undergoing consolidation in an effort to reduce costs and expand programs to better serve the growing need for inpatient behavioral healthcare services.

Diversified revenue and payor bases. As of December 31, 2015, we operated 258 facilities in 39 states, the United Kingdom and Puerto Rico. On a pro forma basis as of December 31, 2015, giving effect to the Priory acquisition, we would have operated 585 facilities in 39 states, the United Kingdom and Puerto Rico. Our payor, patient and geographic diversity mitigates the potential risk associated with any single facility. For the year ended December 31, 2015, we received 33% from Medicaid, 20% from the NHS (including Local Authorities in the United Kingdom), 23% from commercial payors, 12% from Medicare and 12% from other payors. On a pro forma basis for the year ended December 31, 2015, giving effect to the 2014 and 2015 Acquisitions and the Priory acquisition, we would have received 23% of our revenue from Medicaid, 41% from the NHS (including Local Authorities in the United Kingdom), 16% from commercial payors, 8% from Medicare and 12% from other payors. As we receive Medicaid payments from 43 states, the District of Columbia and Puerto Rico, management does not believe that we are significantly affected by changes in reimbursement policies in any one state or territory. Substantially all of our Medicaid payments relate to the care of children and adolescents. Management believes that children and adolescents are a patient class that is less susceptible to reductions in reimbursement rates. No facility accounted for more than 2% of revenue for the year ended December 31, 2015 on a pro forma basis giving effect to the 2014 and 2015 Acquisitions and the Priory acquisition, and no state or U.S. territory accounted for more than 6% of revenue for the year ended December 31, 2015. We believe that our increased geographic diversity will mitigate the impact of any financial or budgetary pressure that may arise in a particular state or market where we operate.

Strong cash flow generation and low capital requirements. We generate strong free cash flow by profitably operating our business and by actively managing our working capital. Moreover, as the behavioral healthcare business does not typically require the procurement and replacement of expensive medical equipment, our maintenance capital expenditure requirements are generally less than that of other facility-based healthcare providers. For the year ended December 31, 2015, our maintenance capital expenditures amounted to approximately 3% of our revenue. In addition, our accounts receivable management is less complex than medical/surgical hospital providers because behavioral healthcare facilities have fewer billing codes and generally are paid on a per diem basis.

Business Strategy

We are committed to providing the communities we serve with high-quality, cost-effective behavioral healthcare services, while growing our business, increasing profitability and creating long-term value for our stockholders. To achieve these objectives, we have aligned our activities around the following growth strategies:

Increase margins by enhancing programs and improving performance at existing facilities. Management believes we can improve efficiencies and increase operating margins by utilizing our management's expertise and experience within existing programs and their expertise in improving performance at underperforming facilities. Management believes the efficiencies can be realized by investing in growth in strong markets, addressing capital-constrained facilities that have underperformed and improving management systems. Furthermore, our recent acquisitions of additional facilities give us an opportunity to develop a marketing strategy in many markets which should help us increase the geographic footprint from which our existing facilities attract patients and referrals.

Opportunistically pursue acquisitions. With the completed acquisitions of Priory, CRC and Partnerships in Care, we have positioned our company as a leading provider of mental health services in the United States and the United Kingdom. The behavioral healthcare industry in the United States and the independent behavioral healthcare industry in the United Kingdom are highly fragmented, and we selectively seek opportunities to expand and diversify our base of operations by acquiring additional facilities. Acadia management believes there are a number of acquisition candidates available at attractive valuations, and we have a number of potential acquisitions in various stages of development and consideration in the United States. In addition, management sees meaningful opportunities to pursue additional select acquisitions in the United Kingdom.

Management believes our focus on behavioral healthcare and history of completing acquisitions provides us with a strategic advantage in sourcing, evaluating and closing acquisitions. We leverage our management team's expertise to identify and integrate acquisitions based on a disciplined acquisition strategy that focuses on quality of service, return on investment and strategic benefits. We also have a comprehensive post-acquisition strategic plan to facilitate the integration of acquired facilities that includes improving facility operations, retaining and recruiting psychiatrists and other healthcare professionals and expanding the breadth of services offered by the facilities.

Drive organic growth of existing facilities. We seek to increase revenue at our facilities by providing a broader range of services to new and existing patients and clients. In addition, management intends to increase bed counts in our existing facilities. During the year ended December 31, 2015, we acquired 176 facilities and added 670 new beds, including 460 to our existing facilities and 210 in two de novo facilities. Furthermore, management believes that opportunities exist to leverage out-of-state referrals to increase volume and minimize payor concentration in the United States, especially with respect to our youth and adolescent focused services and our substance abuse services.

U.S. Operations

Our U.S. facilities and services can generally be classified into the following categories: acute inpatient psychiatric facilities; specialty treatment facilities; residential treatment centers; and outpatient community-based services. The table below presents the percentage of our total revenue attributed to each category on a pro forma basis giving effect to the 2014 and 2015 Acquisitions for the year ended December 31, 2015:

Facility/Service	Revenue for the Year Ended December 31, 2015
Acute inpatient psychiatric facilities	40%
Specialty treatment facilities	41%
Residential treatment centers	16%
Outpatient community-based services	3%

We receive payments from the following sources for services rendered in our U.S. facilities: (i) state governments under their respective Medicaid and other programs; (ii) commercial insurers; (iii) the federal government under the Medicare

program administered by CMS; and (iv) individual patients and clients. For the year ended December 31, 2015 in our U.S. facilities, we received 41% from Medicaid, 29% from commercial payors, 15% from Medicare and 15% from other payors. On a pro forma basis for the year ended December 31, 2015 in our U.S. facilities, giving effect to the 2014 and 2015 Acquisitions, we would have received 42% of our revenue from Medicaid, 29% from commercial payors, 15% from Medicare and 16% from other payors.

At December 31, 2015, our U.S. facilities included 204 behavioral healthcare facilities with approximately 7,700 beds in 39 states and Puerto Rico. Of the 204 behavioral healthcare facilities, 109 are comprehensive treatment centers, of which 98 are leased properties. Of the remaining 95 facilities, 71 are owned properties and 24 are leased properties.

Acute Inpatient Psychiatric Facilities

Acute inpatient psychiatric facilities provide a high level of care in order to stabilize patients that are either a threat to themselves or to others. The acute setting provides 24-hour observation, daily intervention and monitoring by psychiatrists. Generally, due to shorter lengths of stay, the related higher patient turnover, and the special security and health precautions required, acute inpatient psychiatric facilities have lower average occupancy than residential treatment centers. Our facilities that offer acute care services provide evaluation and crisis stabilization of patients with severe psychiatric diagnoses through a medical delivery model that incorporates structured and intensive medical and behavioral therapies with 24-hour monitoring by a psychiatrist, psychiatric trained nurses, therapists and other direct care staff. Lengths of stay for crisis stabilization and acute care range from three to five days and from five to twelve days, respectively.

Specialty Treatment Facilities

Our specialty treatment facilities include residential recovery facilities, eating disorder facilities and comprehensive treatment centers ("CTCs"). We provide a comprehensive continuum of care for adults with addictive disorders and co-occurring mental disorders. Our detoxification, inpatient, partial hospitalization and outpatient treatment programs are cost-effective and give patients access to the least restrictive level of care. All programs offer individualized treatment in a supportive and nurturing environment.

The majority of our specialty treatment services are provided to patients who abuse addictive substances such as alcohol, illicit drugs or opiates, including prescription drugs. Some of our facilities also treat other addictions and behavioral disorders such as chronic pain, sexual compulsivity, compulsive gambling, mood disorders, emotional trauma and abuse. The goal of our treatment facilities is to provide the appropriate level of treatment to an individual no matter where they are in the lifecycle of their disease in order to restore the individual to a healthier, more productive life, free from dependence on illicit substances and destructive behaviors. Our treatment facilities provide a number of different treatment services such as assessment, detoxification, medication-assisted treatment, counseling, education, lectures and group therapy. We assess and evaluate the medical, psychological and emotional needs of the patient and addresses these needs in the treatment process. Following this assessment, an individualized treatment program is designed to provide a foundation for a lifelong recovery process. Many modalities are used in our treatment programs to support the individual, including the twelve step philosophy, cognitive/behavioral therapies, supportive therapies and continuing care.

Residential Recovery Facilities. Our inpatient facilities house and care for patients over an extended period and typically treat patients from a broadly defined regional market. We provide three basic levels of residential treatment depending on the severity of the patient's addiction and/or behavioral disorder. Patients with the most severe dependencies are typically placed into inpatient treatment, in which the patient resides at a treatment facility. If a patient's condition is less severe, he or she will be offered day treatment, which allows the patient to return home in the evening. The least intensive service is where the patient visits the facility for just a few hours a week to attend counseling/group sessions.

Following primary treatment, our extended care programs typically offer residential care, which allows patients to develop healthy and appropriate living skills while remaining in a safe and nurturing setting. Patients are supported in their recovery by a semi-structured living environment that allows them to begin the process of employment or to pursue educational goals and to take personal responsibility for their recovery. The structure of this treatment phase is monitored by a primary therapist who works with each patient to integrate recovery skills and build a foundation of sobriety with a strong support system. Length of stay will vary depending on the patient's needs with a minimum stay of 30 days and could be multiple months if needed.

Our outpatient clinics serve patients that do not require inpatient treatment or are transitioning from a residential treatment program; have employment, family or school commitments; and have stabilized in their substance addiction recovery practices and are seeking ongoing continuing care.

Eating Disorder Facilities. Our eating disorder facilities provide treatment services for eating disorders and weight management, each of which may be effectively treated through a combination of medical, psychological and social treatment programs.

Comprehensive Treatment Centers. Our CTCs specialize in providing medication-assisted and abstinent-based treatment. Medication-assisted treatment combines behavioral therapy and medication to treat substance use disorders. CTCs utilize medication-assisted treatment to individuals addicted to opiates such as opioid analgesics (prescription pain medications) and heroin. Medication is used to normalize brain chemistry to block the euphoric effects of alcohol and opioids allowing our professional staff to provide behavioral therapy. Patients begin their treatment attending the clinic almost daily. Then, through successfully progressing in treatment, patients attend less frequently depending on individual treatment plans. The length of treatment differs from patient to patient, but typically ranges from one to three years.

Each of our CTCs provide a range of comprehensive substance abuse treatment support services that include medical, counseling, vocational, educational, and other treatment services. Our behavioral therapies are delivered in array of treatment models that may include individual and group therapy, intensive outpatient, outpatient, partial hospitalization/day treatment, road to recovery, and other programs that can be either abstinent or medication assisted based.

Residential Treatment Centers

Residential treatment centers treat patients with behavioral disorders in a non-hospital setting, including outdoor programs. The facilities balance therapy activities with social, academic and other activities. Because the setting is less intensive, demands on staffing, security and oversight are generally lower than inpatient psychiatric facilities. In contrast to acute care psychiatric facilities, occupancy in residential treatment centers can be managed more easily given a longer length of stay. Over time, however, residential treatment centers have continued to serve increasingly severe patients who would have been treated in acute care facilities in earlier years.

We provide residential treatment care through a medical model residential treatment facility, which offers intensive, medically-driven interventions and individualized treatment regimens designed to deal with moderate to high level patient acuity. Children and adolescents admitted to these facilities typically have had multiple prior failed treatment plans, severe physical, sexual and emotional abuse, termination of parental custody, substance abuse, marked deficiencies in social, interpersonal and academic skills and a wide range of psychiatric disorders. Treatment typically is provided by an interdisciplinary team coordinating psychopharmacological, individual, group and family therapy, along with specialized accredited educational programs in both secure and unlocked environments. Lengths of stay range from three months to several years.

Certain of our residential treatment centers provide group home, therapeutic group home and therapeutic foster care programs. Our group home programs provide family-style living for youths in a single house or apartment within residential communities where supervision and support are provided by 24-hour staff. The goal of a group home program is to teach family living and social skills through individual and group counseling sessions within a real life environment. The residents are encouraged to take responsibility for the home and their health as well as actively take part in community functions. Most attend an accredited and licensed on-premises school or a local public school. We also operate therapeutic group homes that provide comprehensive treatment services for seriously, emotionally disturbed adolescents. The ultimate goal is to reunite or place these children with their families or prepare them, when appropriate, for permanent placement with a relative or an adoptive family. We also manage therapeutic foster care programs, which are considered the least restrictive form of therapeutic placement for children and adolescents with emotional disorders. Children and adolescents in our therapeutic foster care programs often are part of the child welfare or juvenile justice system. Care is delivered in private homes with experienced foster parents who are trained to work with children and adolescents with special needs.

Outpatient Community-Based Services

Our community-based services can be divided into two age groups: children and adolescents (seven to 18 years of age) and young children (three months to six years of age). Community-based programs are designed to provide therapeutic treatment to children and adolescents who have a clinically-defined emotional, psychiatric or chemical dependency disorder while enabling the youth to remain at home and within their community. Many patients who participate in community-based programs have transitioned out of a residential facility or have a disorder that does not require placement in a facility that provides 24-hour care.

Community-based programs developed for these age groups provide a unique array of therapeutic services to a very high-risk population of children. These children suffer from severe congenital, neurobiological, speech/motor and early onset psychiatric disorders. These services are provided in clinics and employ a treatment model that is consistent with our interdisciplinary medical treatment approach. Depending on their individual needs and treatment plan, children receive speech, physical, occupational and psychiatric interventions that are coordinated with services provided by their referring primary care physician. The children generally receive treatment during regular business hours.

U.K. Operations

Overview

With the Priory and Partnerships in Care acquisitions, we are the leading independent provider of mental health services in the United Kingdom, operating 381 inpatient behavioral health facilities with approximately 9,300 beds. The facilities are located in England, Wales, Scotland and Northern Ireland. For the year ended December 31, 2015 and 2014, our U.K. facilities generated revenue of $360.7 million and $151.1 million, respectively, primarily through the operation and management of inpatient behavioral health facilities.

United Kingdom Mental Health Industry

In the United Kingdom, central government spending on health for fiscal year 2015-2016 is budgeted at approximately £141 billion, according to the United Kingdom government budget. This spending is primarily delivered by the NHS, a national public sector body. Local government spending on health and social care for the fiscal year 2015-2016 is budgeted at approximately £25.1 billion and is commissioned by Local Authorities in the United Kingdom, which we refer to as Local Authorities. The NHS and Local Authorities dominate the United Kingdom healthcare market in terms of the funding of care, with private health insurers and self-payment playing a lesser role in the sector.

The mental health market in the United Kingdom accounted for approximately £14.4 billion in 2011. The independent mental health market accounted for roughly £1.1 billion of that amount, or approximately 8% market share. As a result of government budget constraints and an increased focus on quality, the independent mental health market has witnessed significant expansion in the last decade, making it one of the fastest growing sectors in the United Kingdom healthcare industry.

Mental health services in the United Kingdom are provided through three separate commissioning entities, each with their own separate budget and defined service responsibilities. The three entities are as follows: (i) Local Area Teams, which commission specialist mental health services (e.g., secure facilities and some acute facilities), (ii) Clinical Commissioning Groups, which commission all acute, rehabilitation and most community based services, and (iii) Local Authorities, which commission the remaining community mental health services (which focus primarily on learning disability services). In recent years, the NHS has placed increasing emphasis on implementing integrated care pathways in its mental health commissioning strategy, and the three commissioning entities are currently working to implement an integrated care pathways strategy through which all the services within the secure pathway are commissioned from the same provider (or provider consortium). Integrated care pathways provide patients with highly coordinated and personalized care overseen by a single provider that can monitor patient progression through each stage of the care pathway.

Additionally, commissioning trends toward moving patients more quickly down care pathways, out of secure settings and into community focused care teams have increased the demand for community and rehabilitation services in the independent mental health market. The United Kingdom Department of Health recently identified priorities for essential change in mental health that include, among other things, funding providers based on the quality of their service rather than volume of patients, allocating funds to support specialized housing for people with mental health problems and adopting a new rating system and inspection process to improve the quality of care. Increasing political focus on the provision of mental health services in the United Kingdom and increasing support for the rights of mental health patients are expected to lead to further increases in the size of the mental health market in the United Kingdom. In addition, rising demand for mental health services in the United Kingdom coupled with a constrained mental healthcare funding environment are increasing pressure to improve operational efficiency and refer patients to single provider programs with care pathways that more appropriately reflect each patient's specific mental health needs. As a result of these pressures and an increased focus on quality, the independent mental health market has witnessed significant expansion in the last decade, making it one of the fastest growing sectors in the United Kingdom healthcare industry.

Description of U.K. Facilities

In the United Kingdom, we provide inpatient services through a variety of facilities, including mental health hospitals, clinics, care homes, schools, colleges and children's homes. In addition to these services, we also operate a U.K. division that leverages on our clinical knowledge to provide Employee Assistance Programs ("EAP") to organizations.

Our U.K. facilities and services can generally be classified into the following categories: healthcare facilities, education and children's services, adult care facilities and elderly care facilities. The table below presents the percentage of our total revenue attributed to each category on a pro forma basis giving effect to the 2014 and 2015 Acquisitions and the Priory acquisition for the year ended December 31, 2015:

Facility/Service	Revenue for the Year Ended December 31, 2015
Healthcare facilities	65%
Education and Children's Services	13%
Adult Care facilities	13%
Elderly Care facilities	9%

We receive payments from the NHS (including over 400 Local Authorities) and individual patients and clients. For the year ended December 31, 2015 in our U.K. facilities, we received 99% of our revenue from the NHS (including Local Authorities) and 1% from other payors. On a pro forma basis for the year ended December 31, 2015 in our U.K. facilities, giving effect to the 2014 and 2015 Acquisitions and the Priory acquisition, we would have received 93% of our revenue from the NHS (including Local Authorities) and 7 % from other payors.

At December 31, 2015, our U.K. facilities included 54 behavioral healthcare facilities with approximately 2,200 beds in the United Kingdom. At December 31, 2015, all of our U.K. Facilities were owned properties.

Healthcare

In the United Kingdom, mental health hospitals provide psychiatric treatment and nursing for sufferers of mental disorders, specifically for patients detained under a section of the United Kingdom's Mental Health Act of 1983, and whose risk of harm to others and risk of escape from hospitals cannot be managed safely within other mental health settings. In order to manage the risks involved with treating patients, the facility is managed through the application of a range of security measures depending on the level of dependency and risk exhibited by the patient. The levels of dependency and risk stemming from the wide range of disorders treated at these hospitals determine the level of care provided, which are comprised of:

- *Secure Services.* Medium secure facilities treat patients who may present a serious danger to others and themselves but do not need the physical security arrangements of a high security hospital. The purpose of medium secure services is to provide effective care and treatment to reduce risk, promote recovery and support patients moving through the care pathway to lower levels of security or to reestablishing themselves successfully in the community. Low secure facilities provide treatment for patients whom, because of the level of risk or challenge they present, cannot be treated in open mental health settings. Low secure services deliver intensive, comprehensive and multidisciplinary treatment to patients demonstrating disturbed behavior in the context of a serious mental disorder and require the provision of security but pose a lesser risk of harm to themselves and to others.
- *Specialty Treatment Services.* Specialty treatment services provide treatment relating to eating disorders and addiction. Our eating disorder facilities provide treatment services for eating disorders and weight management for both adults and adolescents. Our addiction services provide treatment for abuse of addictive substances such as alcohol and illicit drugs as well as facilities for other addictions and behavioral disorders such as compulsive gambling.
- *Child and Adolescent Mental Health Services.* Child and adolescent mental health services provide treatment to young people in need of expert care and support for behavioral, emotional or mental health difficulties. These services are designed to enable the children and young people within our care to improve their long-term wellbeing and effectively reintegrate into the community when they are ready.
- *Rehabilitation Services.* Both locked and open mental health rehabilitation services provide a bridge between secure hospital facilities and community living by providing relapse prevention and social integration services as well as vocational opportunities.
- *Acute Services.* Acute services provide treatment relating to emergency admissions for patients at risk to themselves or others, as well as crisis intervention and treatment of behavioral emergencies.

- *Care Homes*. Care homes provide long-term, non-acute care for adults suffering from a mental illness or addiction, or who have a learning disability or brain injury and are unable to cope unsupported in the community.

Other Services

- *Education and Children's Services*. Education and children's services provide specialist education for children and young people with special educational needs, including autism, Asperger's Syndrome, social, emotional and mental health, and specific learning difficulties, such as dyslexia. The division also offers standalone children's homes for children that require 52-week residential care to support complex and challenging behavior and fostering services.
- *Adult Care*. Adult Care focuses on care of service users with a variety of learning difficulties, mental health illnesses and adult autism spectrum disorders. Care is provided in a number of settings, including in residential care homes and through supported living.
- *Elderly Care*. Elderly care provides long-term, short-term and respite nursing care to high-dependency elderly individuals who are physically frail or suffering from dementia.
- *Care First*. Care First leverages our clinical knowledge to provide EAP to organizations. These support services are designed to help employees manage difficult issues in their professional or personal lives with services that include:
  - A call center for telephone counseling available 24-hours a day, seven days a week;
  - A national network of counselors available for live, face-to-face support;
  - Interactive health and wellness programs;
  - Debt management advice services; and
  - Management training.

Sources of Revenue

We receive payments from the following sources for services rendered in our facilities: (i) state governments under their respective Medicaid and other programs; (ii) commercial insurers; (iii) the federal government under the Medicare program administered by the Centers for Medicare and Medicaid Services ("CMS"); (iv) the NHS (including Local Authorities in the United Kingdom); and (v) individual patients and clients. Revenue is recorded in the period in which services are provided at established billing rates less contractual adjustments based on amounts reimbursable by Medicare or Medicaid under provisions of cost or prospective reimbursement formulas or amounts due from other third-party payors at contractually determined rates. See "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations – Revenue" for additional disclosure. Other information related to our revenues, income and other operating information is provided in our Consolidated Financial Statements.

Regulation

U.S. Overview

The healthcare industry is subject to numerous laws, regulations and rules including, among others, those related to government healthcare program participation requirements, various licensure and accreditation standards, reimbursement for patient services, health information privacy and security rules, and government healthcare program fraud and abuse provisions. Providers that are found to have violated any of these laws and regulations may be excluded from participating in government healthcare programs, subjected to loss or limitation of licenses to operate, subjected to significant fines or penalties and/or required to repay amounts received from the government for previously billed patient services. Management believes we are in substantial compliance with all applicable laws and regulations and is not aware of any material pending or threatened investigations involving allegations of wrongdoing.

Licensing, Certification and Accreditation

All of our facilities must comply with various federal, state and local licensing and certification regulations and undergo periodic inspection by licensing agencies to certify compliance with such regulations. The initial and continued licensure of our facilities and certification to participate in government healthcare programs depends upon many factors including various state licensure regulations relating to quality of care, environment of care, equipment, services, staff training, personnel and the existence of adequate policies, procedures and controls. Federal, state and local agencies survey our facilities on a regular basis to determine whether the facilities are in compliance with regulatory operating and health standards and conditions for participating in government healthcare programs.

Most of our residential facilities maintain accreditation from private entities, such as The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities ("CARF"). The Joint Commission and CARF are private organizations that have accreditation programs for a broad spectrum of healthcare facilities. The Joint Commission accredits a broad variety of healthcare organizations, including hospitals and behavioral health organizations. CARF accredits behavioral health organizations providing mental health and alcohol and drug use and addiction services, as well as opiate treatment programs, and many other types of programs. These accreditation programs are intended generally to improve the quality, safety, outcomes and value of healthcare services provided by accredited facilities. Accreditation is generally a requirement for participation in government and private healthcare payment programs. In addition, certain federal and state licensing agencies require that providers be accredited. Accreditation is typically granted for a specified period, typically ranging from one to three years, and renewals of accreditation generally require completion of a renewal application and an on-site renewal survey.

Certificates of Need

Many of the states in which we operate facilities have enacted certificate of need ("CON") laws that regulate the construction or expansion of certain healthcare facilities, certain capital expenditures or changes in services or bed capacity. Failure to obtain CON approval of certain activities can result in: our inability to complete an acquisition, expansion or replacement; the imposition of civil penalties; the inability to receive Medicare or Medicaid reimbursement; or the revocation of a facility's license, any of which could harm our business.

Utilization Review

Federal regulations require the treatment of patients in government healthcare programs be reviewed to confirm efficient utilization of facilities and services. The regulations require Quality Improvement Organizations ("QIOs") and other agencies to review the appropriateness of Medicare and Medicaid patient admissions and discharges, the quality of care provided, the validity of diagnosis related group classifications and the appropriateness of length of stay. The agencies may deny payment for services provided, assess fines, or recommend to the Department of Health and Human Services and other regulatory agencies that a provider that is in substantial non-compliance with the Medicare Conditions of Participation be excluded from participating in the Medicare program.

Audits

Our healthcare facilities are subject to federal, state and commercial payor audits to validate the accuracy of claims submitted to the government healthcare programs and commercial payors. If these audits identify overpayments, we could be required to make substantial repayments, subject to various appeal rights. Several of our facilities have undergone claims audits related to their receipt of payments during the last several years with no material overpayments identified. However, potential liability from future audits could ultimately exceed established reserves, and any excess could potentially be substantial. Further, Medicare and Medicaid regulations, as well as commercial payor contracts, also provide for withholding payments in certain circumstances, which could adversely affect our cash flow.

The Anti-Kickback Statute and Stark Law

A provision of the Social Security Act known as the Anti-Kickback Statute prohibits healthcare providers and others from directly or indirectly soliciting, receiving, offering or paying money or other remuneration to other individuals and entities in return for using, referring, ordering, recommending or arranging for such referrals or orders of services or other items paid for by a government healthcare program. The Anti-Kickback Statute may be found to have been violated if only one purpose of the payment or remuneration is to induce referrals. A provider is not required to have actual knowledge or specific intent to commit a violation of the Anti-Kickback Statute to be found guilty of violating the law.

The Office of the Inspector General of the Department of Health and Human Services has issued regulations that provide "safe harbors" from federal Anti-Kickback Statute liability for various activities. The fact that conduct or a business arrangement does not fall within a safe harbor or exception does not automatically render the conduct or business arrangement illegal under the Anti-Kickback Statute. However, conduct and business arrangements falling outside the safe harbors may lead to increased scrutiny by government enforcement authorities.

Although management believes that our arrangements with physicians and other referral sources comply with current law and available interpretations, there can be no assurance that all arrangements comply with an available safe harbor or that regulatory authorities enforcing these laws will determine these financial arrangements do not violate the Anti-Kickback Statute or other applicable laws.

These laws and regulations are extremely complex and, in many cases, we do not have the benefit of regulatory or judicial interpretation. It is possible that different interpretations or enforcement of these laws and regulations could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our arrangements relating to facilities, equipment, personnel, services, capital expenditure programs and operating expenses. A determination that we have violated one or more of these laws, or the public announcement that we are being investigated for possible violations of one or more of these laws, could have a material adverse effect on our business, financial condition or results of operations. In addition, we cannot predict whether other federal or state legislation or regulations will be adopted, what form such legislation or regulations may take or what their impact on us may be.

If we are deemed to have failed to comply with the Anti-Kickback Statute or other applicable laws and regulations, we could be subjected to liabilities, including criminal penalties, civil penalties, and exclusion of one or more facilities from participation in the government healthcare programs. The imposition of such penalties could have a material adverse effect on our business, financial condition or results of operations.

The Social Security Act also includes a provision regarding physician self-referrals, commonly known as the "Stark Law." This law prohibits physicians from referring Medicare patients to healthcare entities in which they or any of their immediate family members have an ownership or other financial interest for the furnishing of any "designated health services." A violation of the Stark Law may result in a denial of payment, require refunds to the Medicare program, civil monetary penalties of up to $15,000 for each violation, civil monetary penalties of up to $100,000 for circumvention schemes, civil monetary penalties of up to $10,000 for each day that entity fails to report required information, exclusion from the government healthcare programs, and additionally could result in penalties for false claims. There are ownership and compensation arrangement exceptions for many customary financial arrangements between physicians and facilities, including the employment exception, personal services exception, lease exception and certain recruitment exceptions. Our financial arrangements with physicians are structured to comply with the statutory exceptions to the Stark Law and related regulations. However, future Stark Law regulations may alter the scope or interpretation of this law in a manner different from the manner in which we have interpreted them. We cannot predict the effect such future regulations will have on us.

Federal False Claims Act and Other Fraud and Abuse Provisions

The Social Security Act also imposes criminal and civil penalties for submitting false claims to the government healthcare programs. False claims include, but are not limited to, billing for services not rendered, billing for services without adequate documentation, misrepresenting the services rendered in order to obtain higher reimbursement, knowingly retaining overpayments and committing cost report fraud. Like the Anti-Kickback Statute, these provisions are very broad.

Violations of the federal False Claims Act are punishable by fines of up to three times the actual damages sustained by the government, plus mandatory civil penalties. There are many potential bases for liability under the False Claims Act. The Fraud Enforcement and Recovery Act of 2009 has expanded the number of actions for which liability may attach under the False Claims Act, eliminating requirements that false claims be presented to federal officials or directly involve federal funds. The Fraud Enforcement and Recovery Act also clarifies that a false claim violation occurs upon the knowing retention of overpayments. In addition, recent changes to the Anti-Kickback Statute have made violations of that law punishable under the civil False Claims Act.

A current trend affecting the healthcare industry is the increased use of the False Claims Act, and, in particular, actions being brought by individuals on the government's behalf under the False Claims Act's qui tam, or whistleblower, provisions. Whistleblower provisions allow private individuals to bring actions on behalf of the government by alleging that the defendant has defrauded the federal government. Further, a number of states have adopted their own false claims provisions as well as their own whistleblower provisions whereby a private party may file a civil lawsuit on behalf of the state.

Further, the Health Insurance Portability and Accountability Act ("HIPAA") broadened the scope of the fraud and abuse laws by adding several criminal provisions for healthcare fraud offenses that apply to all health benefit programs, whether or not payments under such programs are paid pursuant to federal programs. HIPAA also introduced enforcement mechanisms to prevent fraud and abuse under Medicare. There are civil penalties for prohibited conduct, including, but not limited to, billing for medically unnecessary products or services.

HIPAA Administrative Simplification and Privacy and Security Requirements

The administrative simplification provisions of HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH"), require the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. HIPAA also established federal rules protecting the privacy and security of individually identifiable patient health information ("PHI"). The privacy and security regulations control the use and disclosure of PHI and the rights of patients to understand and control how such PHI is used and disclosed. Violations of HIPAA can result in both criminal and civil fines and penalties.

The HIPAA security regulations require healthcare providers to implement administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of PHI. HITECH has strengthened certain HIPAA rules regarding the use and disclosure of PHI, extended certain HIPAA provisions to business associates, and created security breach notification requirements including notifications to the individuals affected by the breach, the Department of Health and Human Services, and in certain cases, the media. HITECH has also increased maximum penalties for violations of HIPAA privacy rules. Management believes that we have been in material compliance with the HIPAA regulations and have developed our policies and procedures to ensure ongoing compliance.

The Emergency Medical Treatment & Labor Act

The Emergency Medical Treatment & Labor Act ("EMTALA") is intended to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination when a request is made for examination or treatment for an emergency medical condition regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with emergency medical conditions. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer must be implemented. EMTALA imposes additional obligations on hospitals with specialized capabilities, such as ours, to accept the transfer of patients in need of such specialized capabilities if those patients present in the emergency room of a hospital that does not possess the specialized capabilities. CMS is currently considering rules that would require our hospitals to accept the transfer of patients in need of psychiatric services even if the patient is already admitted to the transferring hospital.

Mental Health Parity Legislation

The MHPAEA was signed into law in October 2008 and requires health insurance plans that offer mental health and addiction coverage to provide that coverage on par with financial and treatment coverage offered for other illnesses. The MHPAEA has some limitations because health plans that do not already cover mental health treatments are not required to do so, and health plans are not required to provide coverage for every mental health condition published in the Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association. The MHPAEA also contains a cost exemption which operates to exempt a group health plan from the MHPAEA's requirements if compliance with the MHPAEA becomes too costly.

Patient Protection and Affordable Care Act

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (the "PPACA"). The Healthcare and Education Reconciliation Act of 2010 (the "Reconciliation Act"), which contains a number of amendments to the PPACA, was signed into law on March 30, 2010. Two primary goals of the PPACA, combined with the Reconciliation Act (collectively referred to as the "Health Reform Legislation"), are to provide for increased access to coverage for healthcare and to reduce healthcare-related expenses.

On June 28, 2012, the United States Supreme Court upheld the constitutionality of the requirement in PPACA that individuals maintain health insurance or pay a penalty under Congress's taxing power. The Supreme Court upheld the PPACA provision expanding Medicaid eligibility to new populations as constitutional, but only so long as the expansion of the Medicaid program is optional for the states. States that choose not to expand their Medicaid programs to newly eligible populations in PPACA can only lose the new federal Medicaid funding in PPACA but not their eligibility for existing federal Medicaid matching payments.

The Health Reform Legislation expands coverage of uninsured individuals and provides for significant reductions in the growth of Medicare program payments, material decreases in Medicare and Medicaid disproportionate share hospital payments, and the establishment of programs where reimbursement is tied in part to patient outcomes. Based on Congressional Budget Office estimates, the Health Reform Legislation, as enacted, is expected to expand health insurance coverage to approximately 32 to 34 million additional individuals through a combination of public program expansion and private sector health insurance reforms.

Some of the most significant changes will expand the categories of individuals eligible for Medicaid coverage and permit individuals with relatively higher incomes to qualify. The federal government reimburses the majority of a state's Medicaid expenses, and it conditions its payment on the state meeting certain requirements. The federal government currently requires that states provide coverage for only limited categories of low-income adults under 65 years old (e.g., women who are pregnant, and the blind or disabled). In addition, the income level required for individuals and families to qualify for Medicaid varies widely from state to state. While the Health Reform Legislation will greatly expand the number of adults who are eligible for Medicaid, it may not impact our business as Medicaid generally does not reimburse for care provided to adults treated in freestanding behavioral health facilities.

U.K. Overview

The regulatory environment applicable to facilities in the United Kingdom is complex and multifaceted. The regulatory regime is made up of multiple statutes, regulations and minimum standards that are subject to continuous change. The laws and regulations applicable to the United Kingdom facilities include, without limitation, the Mental Capacity Act of 2005, Safeguarding Vulnerable Groups Act of 2006, Mental Health Act of 2007, Health and Social Care Act of 2008 and Corporate Manslaughter and Corporate Homicide Act of 2008. These laws and regulations are predominantly protective in nature and share the same general underlying

purpose to protect vulnerable persons from exploitation or harm. The regulatory requirements relevant to our facilities in the United Kingdom cover our operations from the initial establishments of new facilities, which are subject to registration and licensing requirements, to the recruitment and appointment of staff, occupational health and safety, duty of care to service users, clinical and educational standards, conduct of our professional and support staff and other areas.

Mental Capacity Act of 2005. The Mental Capacity Act of 2005 establishes the process for determining whether a person lacks mental capacity at a particular time and also sets out who can make decisions in those circumstances and how they should go about this. The Act sets out when liability may arise for actions in connection with the care or treatment of persons who lack capacity to consent to such actions.

Safeguarding Vulnerable Groups Act of 2006. The Safeguarding Vulnerable Groups Act of 2006 created the Independent Safeguarding Authority ("ISA"). In December 2012, the ISA merged with the Criminal Records Bureau to form the Discharge and Barring Service ("DBS") and is required to establish and maintain lists of persons barred from working with children and adults. It is a criminal offense for a barred person to seek to work, or work in, activities from which they are barred. It is also generally a criminal offense for an employer to allow a barred person, or person who is not appropriately registered, to work in any regulated activity.

The Mental Health Act of 2007. The Mental Health Act of 2007 regulates the manner in which an individual can be committed or detained against his or her will. The main purpose of the legislation is to ensure that people with serious mental disorders which threaten their health or safety or the safety of the public can be treated irrespective of their consent where it is necessary to prevent them from harming themselves or others. The Act places the burden on the entity detaining a person to prove that the entity has the right to hold the detainee. This places a substantial regulatory burden on service providers to ensure compliance with the law.

The Health and Social Care Act of 2008. The Health and Social Care Act of 2008 ("HSCA"), as amended by the Care Act 2014, established the Care Quality Commission ("CQC") as the registration and regulatory body for health and adult social care in England. Under the HSCA, service providers carrying out "regulated activities" must be registered with the CQC for each separate regulated activity provided. Where the service provider is a company, each regulated activity/location must also have an individual registered as the registered manager. Registration depends both on an assessment of the fitness of the registered provider and also the individual registered manager. Regulated activities include the provision of residential accommodation together with nursing or personal care and the provision of treatment for a disease, disorder or injury by or under the supervision of a social worker or a multidisciplinary team which includes a social worker where the treatment is for a mental disorder.

The Care Act 2014. The Care Act 2014 came into force on April 1, 2015 along with a range of supporting regulations and a single set of statutory guidance. The Care Act 2014 requires Local Authorities to set personal budgets for individuals that are appropriate to meeting those individuals' assessed eligible care and support needs. The Care Act 2014 also imposes new statutory duties upon Local Authorities to ensure the supply of diverse, good quality, local services, including a duty to plan for future demand and to ensure that services are high quality and sustainable.

The regulated activities regulations and the registration regulations issued pursuant to the HSCA place legally binding obligations on health and social care providers. Breach of certain provisions of the HSCA or the regulations is a criminal offense. In addition, a breach may lead to the CQC taking action to suspend, cancel or vary the conditions of registration of a service provider or impose a substantial fine.

Inspections by regulators in the United Kingdom can be carried out on both an announced and an unannounced basis depending on the specific regulatory provisions relating to the different services provided and also depending upon whether the inspection is routine or as a result of specific information regarding the service that has been provided to the regulator. Generally, however, a majority of inspections tend to be unannounced. A failure to comply with laws and regulations, the receipt of a poor inspection report rating or a lower rating, or the receipt of a negative report that leads to a determination of regulatory non-compliance or a failure to cure any defect noted in an inspection report may result in reputational damage, fines, the revocation or suspension of the registration of any facility or a decrease in, or cessation of, the services provided at any given location.

Corporate Manslaughter and Corporate Homicide Act of 2007. The Corporate Manslaughter and Corporate Homicide Act of 2007 provides liability if the way in which a provider's activities are managed or organized causes a person's death and amounts to a gross breach of a relevant duty of care owed to the deceased person.

Regulatory and Enforcement Bodies

The primary healthcare regulatory enforcement bodies in the United Kingdom are Monitor, the CQC, HIW, CCSIW, HIS, SCSWIS and RQIA. In addition, OFSTED, Estyn, Education Scotland and other regulatory bodies regulate and inspect education

services in England, Wales and Scotland, as applicable. These enforcement bodies control and administer the registration, inspection and complaints procedures set out under the applicable laws and regulations. The enforcement bodies have the power to terminate a facility's registration, refuse to register a facility, impose admissions holds, or impose significant fines if a service provider fails to meet the key minimum standards and requirements prescribed under the various laws and regulations. See "Risk Factors—If we fail to comply with extensive laws and government regulations, we could suffer penalties or be required to make significant changes to our operations."

Monitor. Monitor is the sector regulator for healthcare, tasked with regulating all providers of nonexempt NHS funded services in England. Monitor is the general economic and competition regulator. It fulfills this role through licensing health care providers and, together with the NHS England, sets the national price tariff for NHS services. Monitor's role includes regulating clinical commissioning groups, community services and secondary care services, protecting and promoting patients' interests, tackling abuses and dealing with unjustifiable restrictions on competition. Monitor must exercise its functions with a view to preventing anticompetitive behavior in the provision of health care services.

The CQC. The CQC is the independent regulator for health and adult social care in England. The CQC is distinct from Monitor in that it focuses on quality and ensuring the maintenance of standards in health and social care practices. The CQC licenses NHS and adult social care service providers to enable it to keep a check on safety and quality standards. The CQC also carries out facility inspections. Care homes for young adults (including specialist college accommodation) are registered and inspected by the CQC.

HIW. HIW is the independent inspectorate and regulator of all health care in Wales. Certain independent healthcare services are required to register with HIW. HIW also inspects NHS and independent healthcare organizations in Wales to ensure compliance with its and the NHS's standards, policies, guidance and regulations. The HIW Review Service for Mental Health monitors the use of the Mental Health Act 1983 to ensure that it is being used properly on behalf of Welsh Ministers.

CCSIW. Social care and social services in Wales are regulated by the Care and Social Services Inspectorate Wales ("CCSIW"). CCSIW carries out unannounced inspections and measure against regulations. Children's homes in Wales are inspected by CCSIW.

HIS. Healthcare Improvement Scotland ("HIS") is the independent regulator for healthcare services in Scotland. HIS inspects healthcare providers in Scotland to ensure compliance with its standards, policies, guidance and regulations.

SCSWIS. Care services in Scotland are regulated by the Care Inspectorate Scotland (also known as Social Care and Social Work Improvement Scotland) ("SCSWIS") and all care services in Scotland must be registered with them. As well as registration, SCSWIS inspects services against the National Care Standards and they can take action to force services to improve and can close services if necessary. Independent schools with boarding facilities must register their boarding provision with SCSWIS for the regulation of care as a school care accommodation service.

RQIA. In Northern Ireland, the Regulation and Quality Improvement Authority ("RQIA") is Northern Ireland's independent health and social care regulator. RQIA is responsible for registering, inspecting and encouraging improvement in a range of health and social care services in accordance with the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and its supporting regulations. RQIA inspections are based on certain minimum care standards.

OFSTED. The Office for Standards in Education, Children's Services and Skills ("OFSTED") regulates and inspects services in England that care for children and young people, and services providing education and skills for learners of all ages. OFTSED carries out routine day school and further education college inspections to ensure compliance with inspection frameworks.

Estyn. In Wales, the Office of Her Majesty's Inspectorate for Education and Training ("Estyn") inspects quality standards in education and training for children's homes, residential schools and colleges.

Education Scotland. In Scotland, the education provision for independent schools with boarding facilities is regulated by Education Scotland.

Risk Management and Insurance

The healthcare industry in general continues to experience an increase in the frequency and severity of litigation and claims. As is typical in the healthcare industry, we could be subject to claims that our services have resulted in injury to our patients or clients or other adverse effects. In addition, resident, visitor and employee injuries could also subject us to the risk of litigation. While management believes that quality care is provided to patients and clients in our facilities and that we materially comply with all applicable regulatory requirements, an adverse determination in a legal proceeding or government investigation could have a material adverse effect on our business, financial condition or results of operations.

Our statutory workers' compensation program is fully insured with a $500,000 deductible per accident. Our operations have professional and general liability insurance for claims in excess of a $1,000,000 self-insured retention with an insured excess limit of $50 million.

Environmental Matters

We are subject to various federal, state and local environmental laws that: (i) regulate certain activities and operations that may have environmental or health and safety effects, such as the handling, storage, transportation, treatment and disposal of medical waste products generated at our facilities, the identification and warning of the presence of asbestos-containing materials in buildings, as well as the removal of such materials, the presence of other hazardous substances in the indoor environment, and protection of the environment and natural resources in connection with the development or construction of our facilities; (ii) impose liability for costs of cleaning up, and damages to natural resources from, past spills, waste disposals on and off-site, or other releases of hazardous materials or regulated substances; and (iii) regulate workplace safety. Some of our facilities generate infectious or other hazardous medical waste due to the illness or physical condition of our patients. The management of infectious medical waste is subject to regulation under various federal, state and local environmental laws, which establish management requirements for such waste. These requirements include record-keeping, notice and reporting obligations. Each of our facilities has an agreement with a waste management company for the disposal of medical waste. The use of such companies, however, does not completely protect us from violations of medical waste laws or from related third-party claims for clean-up costs.

From time to time, our operations have resulted in, or may result in, non-compliance with, or liability pursuant to, environmental or health and safety laws or regulations. Management believes that our operations are generally in compliance with environmental and health and safety regulatory requirements or that any non-compliance will not result in a material liability or cost to achieve compliance. Historically, the costs of achieving and maintaining compliance with environmental laws and regulations at our facilities have not been material. However, we cannot assure you that future costs and expenses required for us to comply with any new or changes in existing environmental and health and safety laws and regulations or new or discovered environmental conditions will not have a material adverse effect on our business, financial condition or results of operations.

We have not been notified of and management is otherwise currently not aware of any contamination at our currently or formerly operated facilities for which we could be liable under environmental laws or regulations for the investigation and remediation of such contamination and we currently are not undertaking any remediation or investigation activities in connection with any contamination conditions. There may, however, be environmental conditions currently unknown to us relating to our prior, existing or future sites or operations or those of predecessor companies whose liabilities we may have assumed or acquired which could have a material adverse effect on our business.

New laws, regulations or policies or changes in existing laws, regulations or policies or their enforcement, future spills or accidents or the discovery of currently unknown conditions or non-compliances may give rise to investigation and remediation liabilities, compliance costs, fines and penalties, or liability and claims for alleged personal injury or property damage due to substances or materials used in our operations, any of which may have a material adverse effect on our business, financial condition or results of operations.

Competition

The healthcare industry is highly competitive. Our principal competitors include other behavioral healthcare service companies, including UHS, and the NHS in the U.K. We also compete against hospitals and general healthcare facilities that provide mental health services. An important part of our business strategy is to continue making targeted acquisitions of other behavioral health facilities. However, reduced capacity, the passage of mental health parity legislation and increased demand for mental health services are likely to attract other potential buyers, including diversified healthcare companies and possibly other pure-play behavioral healthcare companies.

The mental health services sector in the United Kingdom comprises hospitals or establishments that provide psychiatric treatment for illness or mental disorder at all security and treatment levels. We operate in several highly competitive markets in the United Kingdom with a variety of for-profit, the NHS and other not-for-profit groups in each of our markets. Most competition is regional or local, based on relevant catchment areas and procurement initiatives. The NHS is often the dominant provider, although the trend has been towards increased outsourcing, whereby the NHS is both a provider and customer of mental healthcare services. The NHS (including Local Authorities) accounts for approximately 70% of the total mental health hospital beds providing care in the United Kingdom, with independent providers accounting for the remaining approximately 30% of beds.

In addition to the competition we face for acquisitions, we must also compete for patients. Patients are referred to our behavioral healthcare facilities through a number of different sources, including healthcare practitioners, public programs, other treatment facilities, managed care organizations, unions, emergency departments, judicial officials, social workers, police departments and word of mouth from previously treated patients and their families, among others. These referral sources may instead refer patients to hospitals that are able to provide a full suite of medical services or to other behavioral healthcare centers.

Employees

As of December 31, 2015, we had approximately 26,400 employees, of which approximately 17,800 were employed full-time. At the acquisition date, Priory had over 16,000 employees. As of December 31, 2015, labor unions represented approximately 472 of our employees, at five of our U.S. facilities through eight collective bargaining agreements. Organizing activities by labor unions and certain potential changes in federal labor laws and regulations could increase the likelihood of employee unionization in the future. The Royal College of Nursing is the trade union for all full and part-time nurses, nursing cadets and healthcare assistants in the U.K.

Typically, our inpatient facilities are staffed by a chief executive officer, medical director, director of nursing, chief financial officer, clinical director and director of performance improvement. Psychiatrists and other physicians working in our facilities are licensed medical professionals who are generally not employed by us and work in our facilities as independent contractors or medical staff members.

Seasonality of Demand for Services

Our residential recovery and other inpatient facilities typically experience lower patient volumes and revenue during the holidays, and our child and adolescent facilities typically experience lower patient volumes and revenue during the summer months, holidays and other periods when school is out of session.

Pro Forma Financial Information

This report contains certain unaudited information, including revenue and operating statistics based on revenue, that is presented on a pro forma basis assuming that acquisitions we completed during 2014 and 2015 and the acquisition of Priory occurred as of an earlier date. The unaudited pro forma information gives effect to each acquisition as if it occurred on January 1, 2014. Management believes that the pro forma financial information is helpful given the rapid growth of Acadia through acquisitions. The unaudited pro forma financial information has been prepared using the acquisition method of accounting for business combinations under Generally Accepted Accounting Principles ("GAAP"). The unaudited pro forma financial information is for illustrative purposes only and does not purport to represent what our financial condition or results of operations actually would have been had the events in fact occurred on the assumed date or to project our financial condition or results of operations for any future date or future period. The unaudited pro forma financial information should be read in conjunction with the consolidated financial statements and notes thereto elsewhere in this report and the financial statements of Acadia and the acquired companies in other reports that we have filed with the SEC.

Available Information

Our Internet website address is www.acadiahealthcare.com. We make available our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K and all amendments to those reports free of charge on our website on the Investors webpage under the caption "SEC Filings" as soon as reasonably practicable after such material is electronically filed with, or furnished to, the SEC. The public may read and copy materials filed with the SEC at the Public Reference Room of the SEC at 100 F Street, NE, Washington, D. C. 20549. The public may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-732-0330. The SEC maintains a website that contains reports, proxy and information statements, and other information regarding issuers that file or furnish information electronically with the SEC at www.sec.gov. Our website and the information contained therein or linked thereto are not intended to be incorporated into this Annual Report on Form 10-K.

Item 1A. Risk Factors

Any of the following risks could materially and adversely affect our business, financial condition or results of operations. These risks should be carefully considered before making an investment decision regarding us. The risks and uncertainties described below are not the only ones we face and there may be additional risks that we are not presently aware of or that we currently consider not likely to have a significant impact. If any of the following risks actually occurred, our business, financial condition and operating results could suffer, and the trading price of our common stock could decline.

Review of the acquisition of Priory by the Competition and Markets Authority ("CMA") may delay our integration of Priory or require us to divest part of Priory's or our respective businesses. If we are unable to successfully integrate Priory into our business following completion of competition review, or if divestments of Priory's or our respective businesses are required, our business, financial condition and results of operations may be negatively impacted.

We cannot determine when the CMA will complete its review of the acquisition of Priory and, until such review is complete, we will not be allowed to integrate Priory's business. Further, we may be required by the CMA to divest part of Priory's or our respective businesses. Our business, financial condition and results of operations may suffer, and our expectations for the acquisition of Priory may not be met, if we are not able to integrate Priory's business for an extended period as a result of an ongoing CMA review or if we are required to divest part of Priory's or our respective businesses.

Upon completion of the CMA review, we intend to integrate Priory's business into our current business. Successful integration will depend on our ability to effect any required changes in operations or personnel which may entail unforeseen liabilities. The integration of Priory may expose us to certain risks, including the following: difficulty in integrating Priory in a cost-effective manner; difficulty or delay in the establishment of effective management information and financial control systems, unforeseen legal, regulatory, contractual, employment or other issues arising out of the combination; combining corporate cultures; maintaining employee morale and retaining key employees; potential disruptions to our on-going business caused by our senior management's focus on integrating Priory; and performance of the combined assets not meeting our expectations or plans. A failure to properly integrate Priory could have a corresponding material adverse effect on our business, results of operations, financial condition or prospects.

Fluctuations in our operating results, quarter to quarter earnings and other factors, including incidents involving our patients and negative media coverage, may result in significant decreases in the price of our common stock.

The stock markets experience volatility that is often unrelated to operating performance. These broad market fluctuations may adversely affect the trading price of our common stock and, as a result, there may be significant volatility in the market price of our common stock. If we are unable to operate our facilities as profitably as we have in the past or as our investors expect us to in the future, the market price of our common stock will likely decline when it becomes apparent that the market expectations may not be realized. In addition to our operating results, many economic and seasonal factors outside of our control could have an adverse effect on the price of our common stock and increase fluctuations in our quarterly earnings. These factors include certain of the risks discussed herein, demographic changes, operating results of other healthcare companies, changes in our financial estimates or recommendations of securities analysts, speculation in the press or investment community, the possible effects of war, terrorist and other hostilities, adverse weather conditions, the level of seasonal illnesses, managed care contract negotiations and terminations, changes in general conditions in the economy or the financial markets or other developments affecting the healthcare industry.

Our revenues and results of operations are significantly affected by payments received from the government and third-party payors.

A significant portion of our revenues is derived from government healthcare programs, principally Medicare and Medicaid. On a pro forma basis for the year ended December 31, 2015, giving effect to the 2014 and 2015 Acquisitions and the Priory acquisition, we would have received approximately 31% of our revenue from the Medicare and Medicaid programs.

Government payors, such as Medicaid, generally reimburse us on a fee-for-service basis based on predetermined reimbursement rate schedules. As a result, we are limited in the amount we can record as revenue for our services from these government programs, and if we have a cost increase, we typically will not be able to recover this increase. In addition, the federal government and many state governments, are operating under significant budgetary pressures, and they may seek to reduce payments under their Medicaid programs for services such as those we provide. Government payors also tend to pay on a slower schedule. In addition to limiting the amounts they will pay for the services we provide their members, government payors may, among other things, impose prior authorization and concurrent utilization review programs that may further limit the services for which they will pay and shift patients to lower levels of care and reimbursement. Therefore, if governmental entities reduce the amounts they will pay for our services, or if they elect not to continue paying for such services altogether, our business, financial condition or results of operations could be adversely affected. In addition, if governmental entities slow their payment cycles further, our cash flow from operations could be negatively affected.

Commercial payors such as managed care organizations, private health insurance programs and labor unions generally reimburse us for the services rendered to insured patients based upon contractually determined rates. These commercial payors are under significant pressure to control healthcare costs. In addition to limiting the amounts they will pay for the services we provide their members, commercial payors may, among other things, impose prior authorization and concurrent utilization review programs that may further limit the services for which they will pay and shift patients to lower levels of care and reimbursement. These actions may reduce the amount of revenue we derive from commercial payors.

Changes in these government programs in recent years have resulted in limitations on reimbursement and, in some cases, reduced levels of reimbursement for healthcare services. Payments from federal and state government healthcare programs are subject to statutory and regulatory changes, administrative rulings, interpretations and determinations, requirements for utilization review, and federal and state funding restrictions, all of which could materially increase or decrease program payments, as well as affect the cost of providing service to patients and the timing of payments to facilities. We are unable to predict the effect of recent and future policy changes on our operations. In addition, since most states operate with balanced budgets and since the Medicaid program is often a state's largest program, some states can be expected to enact or consider enacting legislation formulated to reduce their Medicaid expenditures. Furthermore, the recent economic downturn has increased the budgetary pressures on the federal government and many state governments, which may negatively affect the availability of taxpayer funds for Medicare and Medicaid programs. If the rates paid or the scope of services covered by government payors are reduced, there could be a material adverse effect on our business, financial condition and results of operations.

In addition to changes in government reimbursement programs, our ability to negotiate favorable contracts with private payors, including managed care providers, significantly affects the financial condition and operating results of our facilities in the United States. Management expects third-party payors to aggressively manage reimbursement levels and cost controls. Reductions in reimbursement amounts received from third-party payors could have a material adverse effect on our business, financial condition and results of operations.

Our substantial debt could adversely affect our financial health and prevent us from fulfilling our obligations under our financing arrangements.

As of December 31, 2015, we had approximately $2.2 billion of total debt (net of debt issuance costs, discounts and premiums of $35.4 million), which included approximately $1.2 billion of debt under our Amended and Restated Senior Credit Facility, $150.0 million of debt under our 6.125% Senior Notes, $300.0 million of debt under our 5.125% Senior Notes, $650.0 million of debt under our 5.625% Senior Notes and $22.4 million of Lee County (Florida) Industrial Development Authority Healthcare Facilities Revenue Bonds, Series 2010 with stated interest rates of 9.0% and 9.5% (the "9.0% and 9.5% Revenue Bonds"). To finance our acquisition of Priory in February 2016, we also borrowed $955.0 million under the New TLB Facility, increased our TLA Facility by $135.0 million and issued $390.0 million of 6.500% Senior Notes. See "Item 1. Business—Financing Transactions" for additional details regarding our outstanding indebtedness.

Our substantial debt could have important consequences to our business. For example, it could:

- increase our vulnerability to general adverse economic and industry conditions;
- make it more difficult for us to satisfy our other financial obligations;
- restrict us from making strategic acquisitions or cause us to make non-strategic divestitures;
- require us to dedicate a substantial portion of our cash flow from operations to payments on our debt (including scheduled repayments on our outstanding term loan borrowings under the Amended and Restated Senior Credit Facility), thereby reducing the availability of our cash flow to fund working capital, capital expenditures and other general corporate purposes;
- expose us to interest rate fluctuations because the interest on the Amended and Restated Senior Credit Facility is imposed at variable rates;
- make it more difficult for us to satisfy our obligations to our lenders, resulting in possible defaults on and acceleration of such debt;
- limit our flexibility in planning for, or reacting to, changes in our business and the industry in which we operate;
- place us at a competitive disadvantage compared to our competitors that have less debt;

- limit our ability to borrow additional funds; and
- limit our ability to pay dividends, redeem stock or make other distributions.

In addition, the terms of our financing arrangements contain restrictive covenants that limit our ability to engage in activities that may be in our long-term best interests. Our failure to comply with those covenants could result in an event of default which, if not cured or waived, could result in the acceleration of all of our debts, including the Amended and Restated Senior Credit Facility and the Senior Notes.

Servicing our debt will require a significant amount of cash. Our ability to generate sufficient cash to service our debt depends on many factors beyond our control.

Our ability to make payments on and to refinance our debt, to fund planned capital expenditures and to maintain sufficient working capital will depend on our ability to generate cash in the future. This, to a certain extent, is subject to general economic, financial, competitive, legislative, regulatory and other factors that are beyond our control.

We cannot assure you that our business will generate sufficient cash flow from operations or that future borrowings will be available to us under the Amended and Restated Senior Credit Facility or from other sources in an amount sufficient to enable us to service our debt or to fund our other liquidity needs. If our cash flow and capital resources are insufficient to allow us to make scheduled payments on our debt, we may need to reduce or delay capital expenditures, sell assets, seek additional capital or restructure or refinance all or a portion of our debt on or before the maturity thereof, any of which could have a material adverse effect on our business, financial condition or results of operations. We cannot assure you that we will be able to refinance any of our debt on commercially reasonable terms or at all, or that the terms of that debt will allow any of the above alternative measures or that these measures would satisfy our scheduled debt service obligations. If we are unable to generate sufficient cash flow to repay or refinance our debt on favorable terms, it could significantly adversely affect our financial condition and the value of our outstanding debt. Our ability to restructure or refinance our debt will depend on the condition of the capital markets and our financial condition. Any refinancing of our debt could be at higher interest rates and may require us to comply with more onerous covenants, which could further restrict our business operations.

We are subject to a number of restrictive covenants, which may restrict our business and financing activities.

Our financing arrangements impose, and the terms of any future debt may impose, operating and other restrictions on us. Such restrictions affect, and in many respects limit or prohibit, among other things, our and our subsidiaries' ability to:

- incur or guarantee additional debt and issue certain preferred stock;
- pay dividends on our common stock or redeem, repurchase or retire our equity interests or subordinated debt;
- transfer or sell our assets;
- make certain payments or investments;
- make capital expenditures;
- create certain liens on assets;
- create restrictions on the ability of our subsidiaries to pay dividends or make other payments to us;
- engage in certain transactions with our affiliates; and
- merge or consolidate with other companies.

The Amended and Restated Senior Credit Facility also requires us to meet certain financial ratios, including a fixed charge coverage ratio and a consolidated leverage ratio. See "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources —Amended and Restated Senior Credit Facility"

The restrictions may prevent us from taking actions that management believes would be in the best interests of our business, and may make it difficult for us to successfully execute our business strategy or effectively compete with companies that are not similarly restricted. We also may incur future debt obligations that might subject us to additional restrictive covenants that could affect our financial and operational flexibility. Our ability to comply with these covenants in future periods will largely depend on the pricing of our products and services, our success at implementing cost reduction initiatives and our ability to successfully implement our overall business strategy. We cannot assure you that we will be granted waivers or amendments to our financing arrangements if for any reason we are unable to comply with our financial covenants. The breach of any of these covenants and restrictions could result in a default under the indentures governing the Senior Notes or under the Amended and Restated Senior Credit Facility, which could result in an acceleration of our debt.

Table of Contents

Despite our current debt level, we may incur significant additional amounts of debt, which could further exacerbate the risks associated with our substantial debt.

We may incur substantial additional debt, including additional notes and other debt, in the future. Although the indentures governing our outstanding Senior Notes and our Amended and Restated Senior Credit Facility contain restrictions on the incurrence of additional debt, these restrictions are subject to a number of significant qualifications and exceptions, and under certain circumstances, the amount of debt that could be incurred in compliance with these restrictions could be substantial. If new debt is added to our existing debt levels, the related risks that we now face would intensify and we may not be able to meet all our debt obligations.

If we default on our obligations to pay our debt, we may not be able to make payments on our financing arrangements.

Any default under the agreements governing our debt, including a default under the Amended and Restated Senior Credit Facility or the indentures governing our Senior Notes, and the remedies sought by the holders of such debt, could adversely affect our ability to pay the principal, premium, if any, and interest on the Senior Notes and substantially decrease the market value of the Senior Notes. If we are unable to generate sufficient cash flows and are otherwise unable to obtain funds necessary to meet required payments of principal, premium, if any, and interest on our debt, or if we otherwise fail to comply with the various covenants, including financial and operating covenants, in the instruments governing our debt (including the Amended and Restated Senior Credit Facility and the indentures governing the Senior Notes), we would be in default under the terms of the agreements governing such debt. In the event of such default, the holders of such debt could elect to declare all the funds borrowed thereunder to be due and payable, the lenders under the Amended and Restated Senior Credit Facility could elect to terminate their commitments or cease making further loans and institute foreclosure proceedings against our assets, or we could be forced to apply all available cash flows to repay such debt, and, in any such case, we could ultimately be forced into bankruptcy or liquidation. Because the indentures governing the Senior Notes and the agreement governing the Amended and Restated Senior Credit Facility have customary cross-default provisions, if the debt under the Senior Notes or the Amended and Restated Senior Credit Facility is accelerated, we may be unable to repay or refinance the amounts due.

An incident involving one or more of our patients or the failure by one or more of our facilities to provide appropriate care could result in increased regulatory burdens, governmental investigations, negative publicity and adversely affect the trading price of our securities.

Because the patients we treat suffer from severe mental health and chemical dependency disorders, patient incidents, including deaths, assaults and elopements, occur from time to time. If one or more of our facilities experiences an adverse patient incident or is found to have failed to provide appropriate patient care, an admissions hold, loss of accreditation, license revocation or other adverse regulatory action could be taken against us. Any such patient incident or adverse regulatory action could result in governmental investigations, judgments or fines and have a material adverse effect on our business, financial condition and results of operations. In addition, we have been and could become the subject of negative publicity or unfavorable media attention, whether warranted or unwarranted, that could have a significant, adverse effect on the trading price of our securities or adversely impact our reputation and how our referral sources and payors view us.

Expanding our international operations poses additional risks to our business.

Prior to the acquisition of Partnerships in Care, we were engaged in business activities in the United States and Puerto Rico. The acquisition of Partnerships in Care marked our first entry into a foreign market, and we expanded our operations in the United Kingdom as a result of our acquisition of Priory. Our business or financial performance may be adversely affected due to the risks of operating internationally, including but not limited to the following: economic and political instability, failure to comply with foreign laws and regulations and adverse changes in the health care policy of the United Kingdom (including decreases in funding for the services provided by Partnerships in Care and Priory), adverse changes in law and regulations affecting our operations in the United Kingdom, difficulties and costs of staffing and managing our new operations in the United Kingdom. If any of these events were to materialize, they could lead to disruption of our business, significant expenditures and/or damages to our reputation, which could have a material adverse effect on our results of operations, financial condition or prospects.

As a company based outside of the United Kingdom, we will need to take certain actions to be more easily accepted in the United Kingdom. For example, we may need to engage in a public relations campaign to emphasize service quality and company philosophy, preserve local management continuity and business practices and be transparent in our dealings with local governments and taxing authorities. Such efforts will require significant time and effort on the part of our management team. Our results of operation could suffer if these efforts are not successful.

Our acquisition strategy exposes us to a variety of operational and financial risks.

A principal element of our business strategy is to grow by acquiring other companies and assets in the behavioral healthcare industry. Growth, especially rapid growth, through acquisitions exposes us to a variety of operational and financial risks. We summarize the most significant of these risks below.

Integration risks

We must integrate our acquisitions with our existing operations. This process includes the integration of the various components of our business and of the businesses we have acquired or may acquire in the future, including the following:

- additional psychiatrists, other physicians and employees who are not familiar with our operations;
- patients who may elect to switch to another behavioral healthcare provider;
- regulatory compliance programs; and
- disparate operating, information and record keeping systems and technology platforms.

Integrating a new facility could be expensive and time consuming and could disrupt our ongoing business, negatively affect cash flow and distract management and other key personnel from day-to-day operations.

We may not be able to successfully combine the operations of recently acquired facilities with our operations, and even if such integration is accomplished, we may never realize the potential benefits of the acquisition. The integration of acquisitions with our operations requires significant attention from management, may impose substantial demands on our operations or other projects and may impose challenges on the combined business including, but not limited to, consistencies in business standards, procedures, policies, business cultures and internal controls and compliance. Certain acquisitions involve a capital outlay, and the return that we achieved on any capital invested may be less than the return that we would achieve on our other projects or investments. If we fail to complete the integration of recently acquired facilities, we may never fully realize the potential benefits of the related acquisitions.

We are in the process of integrating the business of Partnerships in Care and CRC into our current business. Successful integration depends on the ability to effect any required changes in operations or personnel, which may entail unforeseen liabilities. The integration of these businesses may expose us to certain risks, including the following: difficulty in integrating these businesses in a cost-effective manner, including the establishment of effective management information and financial control systems; unforeseen legal, regulatory, contractual, employment or other issues arising out of the combination; combining corporate cultures; maintaining employee morale and retaining key employees; potential disruptions to our on-going business caused by our senior management's focus on integrating these businesses; and performance of the combined assets not meeting our expectations or plans. A failure to properly integrate these businesses could have a corresponding material adverse effect on our business, results of operations, financial condition or prospects.

Benefits may not materialize

When evaluating potential acquisition targets, we identify potential synergies and cost savings that we expect to realize upon the successful completion of the acquisition and the integration of the related operations. We may, however, be unable to achieve or may otherwise never realize the expected benefits. Our ability to realize the expected benefits from potential cost savings and revenue improvement opportunities is subject to significant business, economic and competitive uncertainties and contingencies, many of which are beyond our control, such as changes to government regulation governing or otherwise impacting the behavioral healthcare industry, reductions in reimbursement rates from third-party payors, reductions in service levels under our contracts, operating difficulties, client preferences, changes in competition and general economic or industry conditions. If we are unsuccessful in implementing these improvements or if we do not achieve our expected results, it may adversely impact our business, financial condition or results of operations.

Assumptions of unknown liabilities

Facilities that we acquire, including the facilities acquired from Priory and CRC, may have unknown or contingent liabilities, including, but not limited to, liabilities for uncertain tax positions, liabilities for failure to comply with healthcare laws and regulations and liabilities for unresolved litigation or regulatory reviews. Although we typically attempt to exclude significant liabilities from our acquisition transactions and seek indemnification from the sellers of such facilities, the purchase agreement with Priory contained minimal representations and warranties about the entities and business that we acquired. In addition, we have no indemnification rights against the sellers under the Priory purchase agreement and all of the purchase price consideration was paid at closing of the Priory acquisition. See "—Our acquisition of Priory and CRC may expose us to unknown or contingent liabilities for which we will not be indemnified" for additional disclosure. Therefore, we may incur material liabilities for the past activities of

acquired entities and facilities. Even in those acquisitions in which we have such rights, we may experience difficulty enforcing the sellers' obligations, or we may incur material liabilities for the past activities of acquired facilities. Such liabilities and related legal or other costs and/or resulting damage to a facility's reputation could negatively impact our business, financial condition or results of operations.

Competing for acquisitions

We face competition for acquisition candidates primarily from other for-profit healthcare companies, as well as from not-for-profit entities. Some of our competitors may have greater resources than we do. As a result, we may pay more to acquire a target business or may agree to less favorable deal terms than we would have otherwise. Our principal competitors for acquisitions have included Universal Health Services and private equity firms. Also, suitable acquisitions may not be accomplished due to unfavorable terms. Further, the cost of an acquisition could result in a dilutive effect on our results of operations, depending on various factors, including the amount paid for an acquired facility, the acquired facility's results of operations, the fair value of assets acquired and liabilities assumed, effects of subsequent legislation and limits on rate increases. In addition, we may have to pay cash, incur debt, or issue equity securities to pay for any such acquisition, which could adversely affect our financial results, result in dilution to our stockholders, result in increased fixed obligations or impede our ability to manage our operations.

Managing growth

Some of the facilities we have acquired or may acquire in the future may have had significantly lower operating margins prior to the time of our acquisition or may have had operating losses prior to such acquisition. If we fail to improve the operating margins of the facilities we acquire, operate such facilities profitably or effectively integrate the operations of the acquired facilities, our results of operations could be negatively impacted.

Our acquisition of Priory and CRC may expose us to unknown or contingent liabilities for which we will not be indemnified.

Priory and its subsidiaries may have unknown or contingent liabilities, including, but not limited to, liabilities for uncertain tax positions, for failure to comply with healthcare laws and regulations and for regulatory reviews or unresolved litigation, including pending matters relating to corporate manslaughter at one Priory facility and other potential significant charges relating to Priory's operations. Although we typically attempt to exclude significant liabilities from our acquisition transactions and seek indemnification from sellers, the purchase agreement with Priory contained minimal representations and warranties about the entities and business that we acquired.

The facilities we acquired in the acquisition of CRC have been and are currently subject to regulatory investigations, including but not limited to investigations by the Department of Justice's Drug Enforcement Administration, including for non-compliance with certain regulatory requirements relating to the improper handling of controlled substances, and as a result may have unknown or contingent liabilities, including, but not limited to, liabilities for uncertain tax positions, for failure to comply with healthcare laws and regulations and for unresolved litigation or regulatory reviews. In addition, the facilities we acquired in the acquisition of CRC have been and are from time to time, subject to various claims and legal actions that arise in the ordinary course of business, including claims for damages for personal injuries, wrongful death, medical malpractice, breach of contract, tort and employment related claims. In these actions, plaintiffs request a variety of damages, including, in some instances, punitive and other types of damages that may not be covered by insurance or may exceed levels of insurance coverage. These liabilities may increase our costs and harm our business. In addition, a substantial number of our patients addicted to opiates are treated with opioid substitution medications. Opioid substitution medications are prescription medications and have substantial risks associated with them. The facilities we acquired in the acquisition of CRC are currently subject to, and may in the future be subject to, claims arising out of illness, injury or death allegedly caused by opioid replacement therapy. If we are unable to address or manage the risks of claims alleging damages caused by opioid replacement therapy, this could have a material adverse impact on our financial condition and results of operations.

We have no indemnification rights against the sellers under the acquisition agreements related to the Priory and CRC acquisitions and all of the purchase price consideration was paid at the closing of each acquisition. Therefore, we may incur material liabilities for the past activities of acquired entities and facilities. Such liabilities and related legal or other costs and/or resulting damage to a facility's reputation could negatively impact our business, financial condition or results of operations.

The majority of our revenue from our operations in the United Kingdom is not guaranteed and is being generated either from spot purchasing or under block or framework agreements where no volume commitments are given. In addition, there can be no assurance that we can achieve any fee rate increases in the future or will not suffer any fee rate decreases.

Any decline in demand for our services in the United Kingdom from publicly funded entities or private payers or any failure by us to extend current agreements or enter into alternative agreements on comparable terms with such entities could have an adverse effect on our average daily census ("ADC"), which would have a corresponding negative impact on our business, results of operations

and financial condition. Further, there can be no assurances that we will be able to implement fee rate increases, which are a driver of our revenue from our operations, or not suffer from any decline in fee rates in the future. Should the effect of any increase in annual wages or other operating costs of the business exceed the effect of any increase in our fee rates or should our fee rates suffer a decline, we would have to absorb any costs that cannot be offset by our fees, which could have a negative impact on our business, results of operations and financial condition.

Publicly funded entities

A significant portion of our services funded by United Kingdom publicly funded entities are commissioned on a spot-purchase basis at prices determined by prevailing market conditions. It is generally a matter for the relevant commissioner to determine whether to use our services, and there is no guarantee that previous spot market purchasing activity by a commissioner will continue in the future or at all. We also have a number of fixed-term framework agreements which grant it preferred provider status with Local Authorities or the NHS typically lasting between one to three years. While we and the commissioners typically agree on pricing for 12 months with discounts related to the number of beds purchased, the commissioners do not make minimum purchasing commitments under such agreements. As such, commissioners may decide to place existing and new service users with our competitors, including their own in-house service providers, on short notice. We also have a small number of fixed-period block contracts, where a set number of beds are paid for at a discount to spot prices regardless of occupancy. As a result, should spot rates for our services increase, we would remain tied to the discounted rate, which could have an adverse effect on our results.

The rates that we charge publicly-funded entities for our services are negotiated individually with commissioners and are generally subject to annual adjustments on April 1 of each year, historically increasing by reference to the Retail Prices Index ("RPI") or Consumer Price Index ("CPI"), and sector specific wage indices. However, the current economic climate and the United Kingdom government's overriding economic policy to reduce the budget deficit means that, in the short term at least, commissioners may require that efficiency savings be made and that fees reflect local and national budget requirements. As a result, there can be no assurance that we can maintain the payment terms of our arrangements with publicly funded entities, including with respect to the timing of payments.

Further, following expiration of contracts there can be no assurance that negotiations with commissioners will result in the extension or renewal of existing arrangements or the entering into of alternative arrangements for those services. In addition, changing commissioning structures and practices, such as those under the Health and Social Care Act 2012, may involve tendering processes which may result in failing to remain or become an approved provider. Commissioners may also require that following the expiration date of current agreements with us, they contract with us on a spot basis rather than through a block arrangement or reduce the number of beds subject to block arrangements. Even if we are successful in extending current agreements or in entering into alternative arrangements, the duration of such extensions or arrangements is uncertain, and we may be unsuccessful in implementing rate increases under such agreements.

Private payers

Although we have agreements in place with a number of private medical insurance ("PMI") plans where pricing is generally agreed annually, there is no obligation on the PMI plans to refer its members to us or to pay for its members to use our services. Further, we may not be able to renew our existing arrangements with PMI plans on terms comparable to what it has achieved in the past. Fee rates for self-paying individuals are adjusted on January 1 of each year depending on capacity and demand in the relevant service markets. Fees paid or reimbursed by PMI plans are typically adjusted in line with specific contract terms and are generally based on RPI and specific wage indices. Demand in both the PMI market and the self-pay is dependent on economic conditions, which impacts the number of people with sufficient income or capital to pay for insurance coverage or treatment themselves.

Structural shifts in the United Kingdom behavioral healthcare market may adversely affect us.

Publicly funded entities

Payments for our services by publicly funded entities in the United Kingdom, particularly the NHS and Local Authorities, account for the vast majority of our U.K. revenues. We expect publicly funded entities in the United Kingdom to continue to generate the significant majority of our revenue from our operations in the United Kingdom. Budget constraints, public spending cuts or other financial pressures could cause such publicly funded entities to spend less money on the type of services that we provide, or political or United Kingdom government policy changes could mean that fewer of such services are purchased by publicly funded entities from independent sector providers, due to a shift in funding sources towards PMI or self-payment.

While the outsourcing by the NHS in England of healthcare services has been increasing in recent years, the need of the NHS in England to achieve substantial efficiency savings is likely to result in continued funding pressure in the pricing of such services. For instance, Monitor, the NHS economic regulator, has determined national "tariffs" across a range of NHS services and has issued extensive guidance on how they are to be applied, including provision for local variations to national tariffs, subject to approval by Monitor. While none of our services are currently subject to national tariffs, the future application of any national tariff on our services could have a material adverse impact on our revenue.

In addition, the allocation of funding responsibility for adult social care will be subject to change over the next few years under the provisions of the Care Act 2014 under which individuals identified as being required to pay for their own care under the relevant means test will be required to take funding responsibility up to a specified lifetime monetary cap, with Local Authorities responsible for the remainder of expenses for personal care, excluding "daily living" expenses. This will potentially place greater funding responsibility with public sector bodies over the longer term, which will potentially exacerbate the current funding challenges faced by such bodies.

Private payers

Payments for our services in the United Kingdom by PMI plans account for a small portion of our U.K. revenue. In addition, payments for our services in the United Kingdom by self-pay patients, who purchase treatment on a spot basis account for a small portion of our U.K. revenues. Many of the patients who use our acute healthcare services in the United Kingdom do so because their PMI plan recognizes our facilities as being an appropriate provider of the psychiatric treatment services required by the patient. Our ability to attract patients who are funded by PMI plans could be adversely impacted if one or more PMI plans withdraws recognition status from our facilities, for example, as a result of a change in a PMI plan's recognition status standards. In addition, many PMI plans have been changing the terms of their policies and shortening the length of time they will cover a stay at one of our U.K. facilities.

There can be no assurance that the entities or individuals who fund our services will not reduce or cease spending on the types of services that we provide or that alternative service or funding models for mental healthcare, learning disabilities care, specialist education or elderly care will not emerge. Any such funding or structural change in the markets where we operate could have a material adverse effect on our ADC, which would have a corresponding negative impact on our business, results of operations and financial condition.

We are reliant upon maintaining strong relationships with commissioners employed by publicly funded entities, psychiatric and other medical consultants, and any reorganization of such publicly funded entities may result in the loss of those relationships.

The relationships that we have with commissioners is a key driver of referrals for our facilities in the United Kingdom. Referrals to our existing Partnerships in Care business by the NHS accounted for a significant percentage of its revenue for the year ended December 31, 2015 and the addition of Priory increases our reliance on such referrals. Should there be a major reorganization of publicly funded entities, such as the NHS reorganization announced in 2010 and implemented between 2012 and 2013, we may need to rebuild such relationships which could result in a decrease in the number of referrals made to our facilities, which could have a corresponding material adverse effect on our business, results of operations, financial condition or prospects. Any actual or perceived deterioration in service quality, any serious incidents at our facilities or any other event that could cause commissioners to prefer other service providers over us could also adversely impact referrals from commissioners. Further, our business also depends, in part, on psychiatric and other medical consultants referring their patients to us for treatment either as in-patients or day patients. From time to time, consultants may decide to relocate or reposition their practices, retire or refer patients elsewhere with the result that there is a decrease in the number of referrals made to our facilities. A deterioration in relationships with commissioners or consultants or the decision by one or more commissioners or consultants to refer patients to our competitors or to stop all referrals would have an adverse effect on the ADC at our facilities in the United Kingdom, which would have a corresponding negative impact on our business, results of operations and financial condition.

Our operating costs are subject to increases, including due to statutorily mandated increases in the wages and salaries of our staff.

The most significant operating expense for our facilities is wage costs, which represent the staff costs incurred in providing our services and running our facilities, and which are primarily driven by the number of employees and pay rates. The number of employees employed by us is primarily linked to the number of facilities we operate and the number of individuals cared for by us. While we can reduce the number of employees should occupancy rates decrease at our facilities, there is a limit on the extent to which this can be done without impacting quality of our services.

Furthermore, in July 2015, a new National Living Wage was announced that will be introduced across the United Kingdom as the National Minimum Wage in April 2016 and this will increase our operating costs and, unless we can increase revenues or reduce other costs, will reduce our margins.

We also have a number of recurring costs including insurance, utilities and rental costs, and may face increases to other recurring costs such as regulatory compliance costs. There can be no assurance that any of our recurring costs will not grow at a faster rate than our revenue. As a result, any increase in our operating costs could have a material adverse effect on our business, results of operations and financial condition.

We care for a large number of vulnerable individuals with complex needs and any care quality deficiencies could adversely impact our brand, reputation and ability to market our services effectively.

Our future growth will partly depend on our ability to maintain our reputation for high quality services and, through successful sales and marketing activities, increased demand for our services. Factors such as health and safety incidents, problems at our facilities, regulatory enforcement actions, negative press or general customer dissatisfaction could lead to deterioration in the level of our quality ratings or the public perception of the quality of our services (including as a result of negative publicity about our industry generally), which in turn could lead to a loss of patient placements, referrals and self-pay patients or service users. Any impairment of our reputation, loss of goodwill or damage to the value of our brand name could have a material adverse effect on our business, results of operations and financial condition.

Many of our service users have complex medical conditions or special needs, are vulnerable and often require a substantial level of care and supervision. There is a risk that one or more service users could be harmed by one or more of our employees, either intentionally, through negligence or by accident. Further, individuals cared for by us have in the past engaged, and may in the future engage, in behavior that results in harm to themselves, our employees or to one or more other individuals, including members of the public. A serious incident involving harm to one or more service users or other individuals could result in negative publicity. Furthermore, the damage to our reputation or to the reputation of the relevant facility from any such incident could be exacerbated by any failure on our part to respond effectively to such incident. While we maintain an electronic incident reporting system, which management actively reviews and against which responses are monitored, have implemented rigorous clinical, educational and other governance procedures, carried out substantial employee training, employee inductions and employment reference procedures, including a criminal background check, for all front line staff and deployed public relations resources to manage both positive and negative publicity, there can be no assurance that an event giving rise to significant negative publicity would not occur. Such negative publicity could have a material adverse effect on our brand, reputation and ADC, which would have a corresponding negative impact on our business, results of operations and financial condition.

We are and in the future may become involved in legal proceedings based on negligence or breach of a contractual or statutory duty from service users or their family members or from employees or former employees.

From time to time, we are subject to complaints and claims from service users and their family members alleging professional negligence, medical malpractice or mistreatment. We are also subject to claims for unlawful detention from time to time when patients allege they should not have been detained under the Mental Health Act or where the appropriate procedures were not correctly followed.

Similarly, there may be substantial claims from employees in respect of personal injuries sustained in the performance of their duties, particularly in respect of incidents involving patients detained under the Mental Health Act and where future employment prospects are impaired. Current or former employees may also make claims against us in relation to breaches of employment legislation.

We may also be involved in coroner's inquests (or the Scottish equivalent) where there is a fatality at one of our facilities in the United Kingdom (such as pending matters relating to corporate manslaughter at one Priory facility) resulting in an adverse coroner's verdict or civil claims by individuals or criminal prosecutions by regulatory authorities. Any fines imposed by the courts are likely to be substantial in view of the Sentencing Council guidelines published in November 2015, which materially increase fines for corporate manslaughter and certain health and safety offenses. There may also be safeguarding incidents at our facilities which, depending on the circumstances, may result in custodial sentences or other criminal sanctions for the member of staff involved.

The incurrence of any legal fees, damage awards or other fines as summarized above as well as any impact on our brand or reputation as a result of being involved in any legal proceedings are likely to have a material adverse impact on our business, results of operations and financial condition.

We handle sensitive personal data in the ordinary course of business and any failure to maintain the confidentiality of such data could result in legal liability and reputational harm.

We process and store sensitive personal data as part of our business. In the event of a security breach, sensitive personal data could become public. We are currently not aware of any material incidences of potential data breach; however, there can be no assurance that such breaches will not arise in future. Although we have in place policies and procedures to prevent such breaches, breaches could occur either as a result of a breach by us or as a result of a breach by a third party to whom we have provided sensitive personal data, and as a result, we could face liability under data protection laws. Such liability may result in sanctions, including fines and/or may cause us to suffer damage to our brand and reputation, which could have a material adverse effect on our business, results of operations and financial condition.

Our insurance may be inadequate, premiums may increase and, if there is a significant deterioration in our claims experience, insurance may not be available on acceptable terms.

We maintain liability insurance intended to cover service user, third party and employee personal injury claims. Due to the structure of our insurance program under which we carry a large self-insured retention, there may be substantial claims in respect of which the liability for damages and costs falls to us before being met by any insurance underwriter. There may also be claims in excess of our insurance cover or claims which are not covered by our insurance due to other policy limitations or exclusions or where we have failed to comply with the terms of the policy. Furthermore, there can be no assurance that we will be able to obtain liability insurance cover in the future on acceptable terms, or without substantial premium increases or at all, particularly if there is a deterioration in our claim experience history. A successful claim against us not covered by or in excess of our insurance coverage could have a material adverse effect on our business, results of operations and financial condition.

Foreign currency exchange rate fluctuations could materially impact our consolidated financial position and results of operations.

The acquisition of Priory significantly expanded our United Kingdom operations. Accordingly, an increased portion of our revenues are derived from operations in the United Kingdom, and we intend to translate revenue and other results denominated in foreign currency into U.S. dollars for our consolidated financial statements. During periods of a strengthening U.S. dollar, our reported international revenue and expenses could be reduced because foreign currencies may translate into fewer U.S. dollars.

In all jurisdictions in which we operate, we are also subject to laws and regulations that govern foreign investment, foreign trade and currency exchange transactions. These laws and regulations may limit our ability to repatriate cash as dividends or otherwise to the United States and may limit our ability to convert foreign currency cash flows into U.S. dollars.

We incurred significant transaction and acquisition-related costs in connection with the Priory, CRC and Partnerships in Care acquisitions.

We incurred substantial costs in connection with the Priory, CRC and Partnerships in Care acquisitions, including transaction-related expenses. In addition, we may incur additional costs to maintain employee morale and to retain key employees, and we will incur substantial fees and costs related to formulating and executing integration plans. Although we expect that the elimination of duplicative costs, as well as the realization of other efficiencies related to the integration of the businesses, should allow us to more than offset incremental transaction and acquisition-related costs over time, this net benefit may not be achieved in the near term, or at all.

Our ability to grow our business through organic expansion either by developing new facilities or by modifying existing facilities is dependent upon many factors.

Our ability to grow our business is dependent on capacity and occupancy at our facilities. Should our facilities reach maximum occupancy, we may need to implement other growth strategies either by developing new facilities or by modifying existing facilities.

Our facilities typically need to be purpose-designed in order to enable the type and quality of service that we provide. Consequently, we must either develop sites to create facilities or purchase or lease existing facilities, which may require substantial modification. We must be able to identify suitable sites and there is no guarantee that such sites will be available at all, or at an economically viable cost or in areas of sufficient demand for our services. The subsequent successful development and construction of a new facility is contingent upon, among other things, negotiation of construction contracts, regulatory permits and planning consents and satisfactory completion of construction. Similarly, our ability to expand existing facilities is also dependent upon various factors, including identification of appropriate expansion projects, permitting, licensure, financing, integration into our relationships with payors and referral sources, and margin pressure as new facilities are filled with patients.

Delays caused by difficulties in respect of any of the above factors may lead to cost overruns and longer periods before a return is generated on an investment, if at all. We may incur significant capital expenditure but due to a regulatory, planning or other reason, may find that we are prevented from opening a new facility or modifying an existing facility. Moreover, even when incurring such development capital expenditure, there is no guarantee that we can fill beds when they become available. Upon operational commencement of a new facility, we typically expect that it will take approximately 12-18 months to reach our targeted occupancy level. Any delays or stoppages in our projects, the unsatisfactory completion or construction of such projects or the failure of such projects to increase our occupancy levels could have a material adverse effect on our ADC, which would have a corresponding negative impact on our business, results of operations and financial condition.

We may fail to deal with clinical waste in accordance with applicable regulations or otherwise be in breach of relevant medical, health and safety or environmental laws and regulations.

As part of our normal business activities, we produce and store clinical waste which may produce effects harmful to the environment or human health. The storage and transportation of such waste is strictly regulated. Our waste disposal services are outsourced and should the relevant service provider fail to comply with relevant regulations, we could face sanctions or fines which could adversely affect our brand, reputation, business or financial condition. Health and safety risks are inherent in the services that we provide and are constantly present in our facilities, primarily in respect of food and water quality, as well as fire safety and the risk that service users may cause harm to themselves, other service users or employees. From time to time, we have experienced, like other providers of similar services, undesirable health and safety incidents. Some of our activities are particularly exposed to significant medical risks relating to the transmission of infections or the prescription and administration of drugs for residents and patients. If any of the above medical or health and safety risks were to materialize, we may be held liable, fined and any registration certificate could be suspended or withdrawn for failure to comply with applicable regulations, which may have a material adverse impact on our business, results of operations and financial condition.

The value of our real estate assets will be subject to fluctuations in the United Kingdom real estate market.

As a result of the acquisition of Priory, we hold a larger portfolio of real estate assets. The value of our U.K. property portfolio is subject to, among other things, the conditions of the real estate market in the United Kingdom. The average values of real estate in the United Kingdom, as in other European countries, experienced sharp declines from 2007 as a result of the credit crisis, economic recession and reduced confidence in global financial markets. Although real estate asset values have recovered and stabilized in recent years in the United Kingdom, there can be no assurance that this improvement will continue or be sustainable. Real estate asset values could decline substantially, particularly if the United Kingdom economy or the Eurozone economy as a whole were to suffer a further recession or debt crisis, and could result in declines in the carrying values of our real estate assets (and the value at which we could dispose of such assets). Any of the above may have a material adverse effect on our business, results of operations and financial condition.

Our business could be disrupted if our information systems fail or if our databases are destroyed or damaged.

Our information technology platform supports, among other things, management control of patient administration, billing and financial information and reporting processes. For example, patients in our U.K. facilities and some of our U.S. facilities have an Electronic Patient Record that allows our caregivers and nurses to see all information about a patient's care and treatment. Although we have taken measures to mitigate potential information technology security risks and have information technology continuity plans across our business intended to minimize the impact of information technology failures, there can be no assurance that such measures and plans will be effective. Any failure in our information technology systems could adversely impact our business, results of operations and financial condition.

We are subject to volatility in the global capital and credit markets as well as significant developments in macroeconomic and political conditions that are out of our control.

Our business can be affected by a number of factors that are beyond our control, such as general macroeconomic conditions, conditions in the financial services markets, geopolitical conditions and other general political and economic developments. These conditions and developments may continue to put pressure on the economy in the United Kingdom, which could have a negative effect on our business. There may be a shortage of liquidity and credit in the United Kingdom or worldwide and this can be exacerbated by adverse developments in global or national political and/or macroeconomic conditions. In particular, we have historically financed the development of new facilities and the modification of our existing facilities through a variety of sources, including our own cash reserves and debt financing. While we intend to seek to finance new and existing developments from similar sources in the future, there may be insufficient cash reserves to fund the budgeted capital expenditure and market conditions and other factors may prevent us from obtaining debt financing on appropriate terms or at all. In addition, market conditions may limit the

number of financial institutions that are willing to provide financing to landlords with whom we wish to contract to build homes for learning disability services, new schools or new mental health facilities which can then be made available to us under a long-term operating lease. If conditions in the United Kingdom or the global economy remain uncertain or weaken further, this could materially adversely impact our ADC, which would have a corresponding negative impact on our business, results of operations and financial condition.

The pro forma financial statements were presented for illustrative purposes only and may not be an indication of our financial condition or results of operations following the acquisition of Priory.

The pro forma financial statements we have filed with the SEC in connection with the acquisition of Priory were presented for illustrative purposes only and may not be an indication of our financial condition or results of operations following the acquisition of Priory for several reasons. For example, the pro forma financial statements were derived from our historical financial statements and Priory's, CRC's and Partnerships in Care's historical financial statements, and certain adjustments and assumptions have been made regarding us after giving effect to the acquisition of CRC. The information upon which these adjustments and assumptions have been made is preliminary, and these kinds of adjustments and assumptions are difficult to make with accuracy. Moreover, our actual financial condition and results of operations following the acquisition of Priory may not be consistent with, or evident from, the pro forma financial statements.

In addition, the assumptions used in preparing the pro forma financial data may not prove to be accurate, and other factors may affect our financial condition or results of operations following the acquisition of Priory. Any potential decline in our financial condition or results of operations may cause significant variations in the trading price of our securities.

We made certain assumptions relating to the acquisition of Priory, CRC and Partnerships in Care in our forecasts that may prove to be materially inaccurate, and we may be unable to achieve the related cost savings or synergies.

We made certain assumptions relating to the forecast level of cost savings, synergies and associated costs of the Priory, CRC and Partnerships in Care acquisitions. Our assumptions relating to the forecast level of cost savings, synergies and associated costs of the Priory, CRC and Partnerships in Care acquisitions may be inaccurate based on the information available to us, including as the result of the failure to realize the expected benefits of the Priory, CRC and Partnerships in Care acquisitions, higher than expected transaction and integration costs and unknown liabilities as well as general economic and business conditions that may adversely affect us. The anticipated cost savings related to the Priory, CRC and Partnerships in Care acquisitions are based upon assumptions about our ability to implement integration measures in a timely fashion and within certain cost parameters. Our ability to achieve the planned cost synergies is dependent upon a significant number of factors, some of which may be beyond our control. For example, we may be unable to eliminate duplicative costs and redundancies in a timely fashion or at all. Other factors that could cause us not to realize the expected cost savings and synergies, include but are not limited to, the following: higher than expected severance costs related to workforce reductions; higher than expected retention costs for employees that will be retained; inability to reduce or eliminate fees relating to professional, outside services and other redundant contracted services in a timely manner or at all; delays in the anticipated timing of activities related to our cost-saving plan including in the reduction of other general and administrative expenses; and other unexpected costs associated with operating our business. In addition, Priory operated at a net loss for the years ended December 31, 2014 and 2015, CRC operated at a net loss for the years ended December 31, 2013 and 2014, and Partnerships in Care operated at a net loss for the year ended December 31, 2013 and the six months ended June 30, 2014, any of which may impact our ability to achieve synergies and profitability from such acquisitions in the near term. Actual cost savings, the costs required to realize the cost savings and the assumptions underlying the cost savings could differ materially from our current expectations, and we cannot assure you that we will achieve the full amount of cost savings on the schedule anticipated or at all.

Failure to comply with the international and U.S. laws and regulations applicable to our international operations could subject us to penalties and other adverse consequences.

We face several risks inherent in conducting business internationally, including compliance with international and U.S. laws and regulations that apply to our international operations. These laws and regulations include U.S. laws such as the Foreign Corrupt Practices Act and other U.S. federal laws and regulations established by the Office of Foreign Asset Control, local laws such as the United Kingdom Bribery Act 2010 or other local laws which prohibit corrupt payments to governmental officials or certain payments or remunerations to customers. Given the high level of complexity of these laws, however, there is a risk that some provisions may be inadvertently breached by us, for example through fraudulent or negligent behavior of individual employees, our failure to comply with certain formal documentation requirements, or otherwise. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or our employees, implementation of compliance programs, and prohibitions on the conduct of our business. Any such violations could include prohibitions on our ability to conduct business in the United Kingdom and could materially damage our reputation, our brand, our international expansion efforts, our ability to attract and retain employees, our business and our operating results. Our success depends, in part, on our ability to anticipate these risks and manage these challenges.

Table of Contents

We are subject to taxation in certain foreign jurisdictions. Any adverse development in the tax laws of such jurisdictions or any disagreement with our tax positions could have a material adverse effect on our business, financial condition or results of operations. In addition, our effective tax rate could change materially as a result of certain changes in our mix of United States and foreign earnings and other factors, including changes in tax laws.

We are subject to taxation in, and to the tax laws and regulations of, certain foreign jurisdictions as a result of our operations and our corporate and financing structure. Adverse developments in these tax laws or regulations, or any change in position regarding the application, administration or interpretation thereof, in any applicable jurisdiction, could have a material adverse effect on our business, financial condition or results of operations. In addition, the tax authorities in any applicable jurisdiction may disagree with the tax treatment or characterization of any of our transactions, which, if successfully challenged by such tax authorities, could have a material adverse effect on our business, financial condition or results of operations. Certain changes in the mix of our earnings between jurisdictions and assumptions used in the calculation of income taxes, among other factors, could have a material adverse effect on our overall effective tax rate. In addition, legislative proposals to change the United States taxation of foreign earnings could also increase our effective tax rate.

A worsening of the economic and employment conditions in the geographies in which we operate could materially affect our business and future results of operations.

During periods of high unemployment, governmental entities often experience budget deficits as a result of increased costs and lower than expected tax collections. These budget deficits at the federal, state and local levels have decreased, and may continue to decrease, spending for health and human service programs, including Medicare and Medicaid in the United States, which are significant payor sources for our facilities. In periods of high unemployment, we also face the risk of potential declines in the population covered under private insurance, patient decisions to postpone or decide against receiving behavioral healthcare services, potential increases in the uninsured and underinsured populations we serve and further difficulties in collecting patient co-payment and deductible receivables.

Substantially all of the revenue from our eating disorder programs, extended care facilities and certain residential treatment facilities is derived from private-pay funding. In addition, a substantial portion of our revenue from our comprehensive treatment centers and youth programs is from self-payors. Accordingly, a sustained downturn in the U.S. economy could restrain the ability of our patients and the families of our students to pay for services.

Furthermore, the availability of liquidity and capital resources to fund the continuation and expansion of many business operations worldwide has been limited in recent years. Our ability to access the capital markets on acceptable terms may be severely restricted at a time when we would like, or need, access to those markets, which could have a negative impact on our growth plans, our flexibility to react to changing economic and business conditions and our ability to refinance existing debt (including debt under our Amended and Restated Senior Credit Facility and the Senior Notes). A sustained economic downturn or other economic conditions could also adversely affect the counterparties to our agreements, including the lenders under the Amended and Restated Senior Credit Facility, causing them to fail to meet their obligations to us.

If we fail to comply with extensive laws and government regulations, we could suffer penalties or be required to make significant changes to our operations.

Companies operating in the behavioral healthcare industry in the United States are required to comply with extensive and complex laws and regulations at the federal, state and local government levels relating to, among other things: billing practices and prices for services; relationships with physicians and other referral sources; necessity and quality of medical care; condition and adequacy of facilities; qualifications of medical and support personnel; confidentiality, privacy and security issues associated with health-related information and PHI; EMTALA compliance; handling of controlled substances; certification, licensure and accreditation of our facilities; operating policies and procedures; activities regarding competitors; state and local land use and zoning requirements; and addition or expansion of facilities and services.

Among these laws are the anti-kickback provision of the Social Security Act (the "Anti-Kickback Statute"), the federal physician self-referral (the "Stark Law"), the federal False Claims Act (the "False Claims Act"), and similar state laws. These laws, and particularly the Anti-Kickback Statute and the Stark Law, impact the relationships that we may have with physicians and other potential referral sources. We have a variety of financial relationships with physicians and other professionals who refer patients to our facilities, including employment contracts, leases and professional service agreements. The Office of the Inspector General of the Department of Health and Human Services has issued certain exceptions and safe harbor regulations that outline practices that are deemed acceptable under the Stark Law and Anti-Kickback Statute. While we endeavor to comply with applicable exceptions and safe harbors, certain of our current arrangements with physicians and other potential referral sources may not qualify for safe harbor protection. Failure to meet a safe harbor does not mean that the arrangement automatically violates the Anti-Kickback Statute, but

may subject the arrangement to greater scrutiny. We cannot offer assurances that practices that are outside of a safe harbor will not be found to violate the Anti-Kickback Statute. Allegations of violations of the Stark Law and Anti-Kickback Statute may be brought under the federal Civil Monetary Penalty Law, which requires a lower burden of proof than criminal violations.

These laws and regulations are extremely complex, and, in many cases, we do not have the benefit of regulatory or judicial interpretation. In the future, it is possible that different interpretations of these laws and regulations could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our arrangements for facilities, equipment, personnel, services, capital expenditure programs and operating expenses. A determination that we have violated one or more of these laws could subject us to liabilities, including civil penalties, exclusion of one or more facilities from participation in the government healthcare programs and, for violations of certain laws and regulations, criminal penalties. Even the public announcement that we are being investigated for possible violations of these laws could cause our reputation to suffer and have a material adverse effect on our business, financial condition or results of operations. In addition, we cannot predict whether other similar legislation or regulations at the federal or state level will be adopted, what form such legislation or regulations may take or what their impact on us may be.

The construction and operation of healthcare facilities in the United States are subject to extensive federal, state and local regulation relating to, among other things, the adequacy of medical care, equipment, personnel, operating policies and procedures, fire prevention, rate-setting, compliance with building codes and environmental protection. Additionally, such facilities are subject to periodic inspection by government authorities to assure their continued compliance with these various standards. If we fail to adhere to these standards, we could be subject to monetary and operational penalties.

All of our facilities that handle and dispense controlled substances must comply with strict federal and state regulations regarding the purchasing, storing, distribution and disposal of such controlled substances. The potential for theft or diversion of such controlled substances for illegal uses has led the federal government as well as a number of states and localities to adopt stringent regulations not applicable to many other types of healthcare providers. Compliance with these regulations is expensive and these costs may increase in the future.

Property owners and local authorities have attempted, and may in the future attempt, to use or enact zoning ordinances to eliminate our ability to operate a given treatment facility or program. Local governmental authorities in some cases also have attempted to use litigation and the threat of prosecution to force the closure of certain comprehensive treatment facilities. If any of these attempts were to succeed or if their frequency were to increase, our revenue would be adversely affected and our operating results might be harmed. In addition, such actions may require us to litigate which would increase our costs.

Many of our U.S. facilities are also accredited by third-party accreditation agencies such as The Joint Commission or CARF. If any of our existing healthcare facilities lose their accreditation or any of our new facilities fail to receive accreditation, such facilities could become ineligible to receive reimbursement under Medicare or Medicaid.

Federal, state and local regulations determine the capacity at which many of our U.S. facilities may be operated. State licensing standards require many of our U.S. facilities to have minimum staffing levels; minimum amounts of residential space per student or patient and adhere to other minimum standards. Local regulations require us to follow land use guidelines at many of our U.S. facilities, including those pertaining to fire safety, sewer capacity and other physical plant matters.

Similarly, providers of behavioral healthcare services in the United Kingdom are also subject to a highly regulated business environment. Failure to comply with regulations, lapses in the standards of care, the receipt of poor ratings or lower ratings, the receipt of a negative report that leads to a determination of regulatory noncompliance, or the failure to cure any defect noted in an inspection report could lead to substantial penalties, including the loss of registration or closure of one or more facilities as well as damage to reputation.

Our operations in the United Kingdom are subject to a high level of regulation and supervision, ranging from the initial establishment of new facilities, which are subject to registration and licensing requirements, to the recruitment and appointment of staff, occupational health and safety, duty of care to service users, clinical and educational standards, conduct of our professional and support staff, the environment, public health and other areas. The regulatory requirements differ across our divisions, though almost all of our activity in England in relation to mental healthcare, elderly care and learning disability care are regulated by the CQC and in Scotland, Wales and Northern Ireland, its local equivalent. In addition, our children's homes, residential schools and colleges in England are regulated by OFSTED, and in Scotland and Wales by their local equivalent, and all of our schools must be licensed by the Department for Education. See "Item 1. Business—Regulation—U.K. Overview" for further details on the key regulations to which we are subject.

Inspections by CQC, OFSTED, and other regulators can be carried out on both an announced and unannounced basis depending on the specific regulatory provisions relating to the different healthcare, social care and specialist education services we provide.

Table of Contents

A failure to comply with regulations, the receipt of a poor rating or a lower rating, or the receipt of a negative report that leads to a determination of regulatory non-compliance or our failure to cure any defect noted in an inspection report could result in reputational damage, fines, the revocation or suspension of the registration of any facility or service or a decrease in, or cessation of, the services provided by us at any given facility. Additionally, where placements are funded by Local Authorities, most Local Authorities monitor performance and where there are shortcomings may impose punitive measures. These can, for example, include the suspension of new placements (known in the industry as "embargoes") and, in extreme cases, removal of all residents placed by that authority, which in turn may affect the level of referrals from other publicly funded entities and our occupancy levels.

Furthermore, new regulations or regulatory bodies may be introduced in the future or existing regulations and regulatory bodies may be amended or replaced and we may not adapt to such changes quickly enough, or in a cost-efficient manner. For example, the United Kingdom government appointed Monitor as the new market regulator for healthcare providers in 2012 by way of a licensing regime. Any failure by us to comply with the licensing regime could result in Monitor revoking our license, which would mean we would be unable to operate. In addition, such regulatory changes may preclude management from executing its business plan as intended, including the timing for new developments and openings.

We cannot guarantee that current laws, regulations and regulatory assessment methodologies will not be modified or replaced in the future. There can be no assurance that our business, results of operations and financial condition will not be adversely affected by any future regulatory developments or that the cost of compliance with new regulations will not be material.

If we fail to cultivate new or maintain established relationships with referral sources, our business, financial condition or results of operations could be adversely affected.

Our ability to grow or even to maintain our existing level of business depends significantly on our ability to establish and maintain close working relationships with physicians, managed care companies, insurance companies, educational consultants and other referral sources. We may not be able to maintain our existing referral source relationships or develop and maintain new relationships in existing or new markets. If we lose existing relationships with our referral sources, the number of people to whom we provide services may decline, which may adversely affect our revenue. If we fail to develop new referral relationships, our growth may be restrained.

Our business in the United Kingdom relies upon maintaining strong relationships with commissioners employed by publicly funded entities and any reorganization of such publicly funded entities may result in the loss of those relationships.

The relationships that the sales and marketing function of our facilities in the United Kingdom holds with commissioners is a key driver of referrals to such facilities. Should there be a major reorganization of publicly funded entities, such as the NHS reorganization announced in 2010 and implemented between 2012 and 2013, we may need to rebuild such relationships which could result in a decrease in the number of referrals made to our facilities in the United Kingdom, and which could have a corresponding material adverse effect on our business, results of operations, financial condition or prospects.

We may be required to spend substantial amounts to comply with statutes and regulations relating to privacy and security of PHI.

There are currently numerous legislative and regulatory initiatives in both the U.S. and the United Kingdom addressing patient privacy and information security concerns. In particular, federal regulations issued under HIPAA require our U.S. facilities to comply with standards to protect the privacy, security and integrity of PHI. These regulations have imposed extensive administrative requirements, technical and physical information security requirements, restrictions on the use and disclosure of PHI and related financial information and have provided patients with additional rights with respect to their health information. Compliance with these regulations requires substantial expenditures, which could negatively impact our business, financial condition or results of operations. In addition, our management has spent, and may spend in the future, substantial time and effort on compliance measures.

In addition to HIPAA, we are subject to similar, and in some cases more restrictive, state and federal privacy requirements. For example, the federal government and some states impose laws governing the use and disclosure of health information pertaining to substance abuse treatment that are more stringent than the rules that apply to healthcare information generally. As public attention is drawn to the issues of the privacy and security of medical information, states may revise or expand their laws concerning the use and disclosure of health information, or may adopt new laws addressing these subjects.

Violations of the privacy and security regulations could subject our operations to substantial civil monetary penalties and substantial other costs and penalties associated with a breach of data security, including criminal penalties. We may also be subject to substantial reputational harm if we experience a substantial security breach involving PHI.

Table of Contents

We may be subject to liabilities from claims brought against us or our facilities.

We are subject to medical malpractice lawsuits and other legal actions in the ordinary course of business. Some of these actions may involve large claims, as well as significant defense costs. We cannot predict the outcome of these lawsuits or the effect that findings in such lawsuits may have on us. All professional and general liability insurance we purchase is subject to policy limitations and in some cases, an insurance company may defend us subject to a reservation of rights. Insurance companies in at least two matters involving Acadia are defending us subject to a reservation of rights. Management believes that, based on our past experience and actuarial estimates, our insurance coverage is adequate considering the claims arising from the operations of our facilities. While we continuously monitor our coverage, our ultimate liability for professional and general liability claims could change materially from our current estimates. If such policy limitations should be partially or fully exhausted in the future, or payments of claims exceed our estimates or are not covered by our insurance, it could have a material adverse effect on our business, financial condition or results of operations. Further, insurance premiums have increased year over year and insurance coverage may not be available at a reasonable cost, especially given the significant increase in insurance premiums generally experienced in the healthcare industry.

We have been and could become the subject of governmental investigations, regulatory actions and whistleblower lawsuits.

Healthcare companies in both the United States and the United Kingdom are subject to numerous investigations by various governmental agencies. Certain of our facilities have received, and other facilities may receive, government inquiries from, and may be subject to investigation by, governmental agencies. Depending on whether the underlying conduct in these or future inquiries or investigations could be considered systemic, their resolution could have a material adverse effect on our business, financial condition and results of operations.

Further, under the False Claims Act, private parties are permitted to bring qui tam or "whistleblower" lawsuits against companies that submit false claims for payments to, or improperly retain overpayments from, the government. Because qui tam lawsuits are filed under seal, we could be named in one or more such lawsuits of which we are not aware. We may also be subject to substantial reputational harm as a result of the public announcement of any investigation into such claims.

We are subject to uncertainties regarding recent health reform and budget legislation.

The expansion of health insurance coverage in the United States under the Patient Protection and Affordable Care Act and the Reconciliation Act, or, collectively, the Health Reform Legislation, may increase the number of patients using our facilities who have either private or public program coverage. In addition, a disproportionately large percentage of new Medicaid coverage is likely to be in states that currently have relatively low income eligibility requirements and may include states where we have facilities. Furthermore, as a result of the Health Reform Legislation, there may be a reduction in uninsured patients, which should reduce our expense from uncollectible accounts receivable.

Notwithstanding the foregoing, the Health Reform Legislation makes a number of other changes to Medicare and Medicaid which management believes may have an adverse impact on us. The various provisions in the Health Reform Legislation that directly or indirectly affect reimbursement are scheduled to take effect over a number of years. Health Reform Legislation provisions are likely to be affected by the incomplete nature of implementing regulations or expected forthcoming interpretive guidance, gradual implementation or future legislation. Further, Health Reform Legislation provisions, such as those creating the Medicare Shared Savings Program and the Independent Payment Advisory Board, create certain flexibilities in how healthcare may be reimbursed by federal programs in the future. Thus, we cannot predict the impact of the Health Reform Legislation on our future reimbursement at this time.

The Health Reform Legislation also contains provisions aimed at reducing fraud and abuse in healthcare. The Health Reform Legislation amends several existing laws, including the federal Anti-Kickback Statute and the False Claims Act, making it easier for government agencies and private plaintiffs to prevail in lawsuits brought against healthcare providers. Congress revised the intent requirement of the Anti-Kickback Statute to provide that a person is not required to have actual knowledge or specific intent to commit a violation of the Anti-Kickback Statute in order to be found guilty of violating such law. The Health Reform Legislation also provides that any claims for items or services that violate the Anti-Kickback Statute are also considered false claims for purposes of the False Claims Act. The Health Reform Legislation provides that a healthcare provider that knowingly retains an overpayment in excess of 60 days is subject to the False Claims Act.

The impact of the Health Reform Legislation on each of our facilities may vary. We cannot predict the impact the Health Reform Legislation may have on our business, results of operations, cash flow, capital resources and liquidity, or whether we will be able to adapt successfully to the changes required by the Health Reform Legislation.

We are similarly unable to guarantee that current United Kingdom laws, regulations and regulatory assessment methodologies will not be modified or replaced in the future. Additionally, there is a risk that budget constraints, public spending cuts (such as the cuts announced by the United Kingdom government in the 2010 Comprehensive Spending Review and implemented in the 2011 and 2012 government budgets) or other financial pressures could cause the NHS to reduce funding for the types of services that we provide. Such policy changes in the United Kingdom could lead to fewer services being purchased by publicly funded entities or material changes being made to their procurement practices, any of which could materially reduce our revenue. These and other future developments and amendments may negatively impact our operations, which could have a material adverse effect on our business, financial condition or results of operations. See "—Expanding our international operations poses additional risks to our business."

Finally, the allocation of funding responsibility for adult social care will be subject to change over the next few years under the provisions of the Care Act 2014 with individuals identified as being required to pay for their own care under the relevant means test being required to take funding responsibility up to a specified lifetime monetary cap, with Local Authorities then becoming responsible for the continued funding of personal care, but not 'daily living' expenses. This will potentially place greater funding responsibility with public sector bodies over the longer term, which will potentially exacerbate the current funding challenges faced by such bodies.

We operate in a highly competitive industry, and competition may lead to declines in patient volumes.

The healthcare industry is highly competitive, and competition among healthcare providers (including hospitals) for patients, physicians and other healthcare professionals has intensified in recent years. There are other healthcare facilities that provide behavioral and other mental health services comparable to those offered by our facilities in each of the geographical areas in which we operate. Some of our competitors are owned by tax-supported governmental agencies or by non-profit corporations and may have certain financial advantages not available to us, including endowments, charitable contributions, tax-exempt financing and exemptions from sales, property and income taxes. Some of our for-profit competitors are local, independent operators or physician groups with strong established reputations within the surrounding communities, which may adversely affect our ability to attract a sufficiently large number of patients in markets where we compete with such providers. We also face competition from other for-profit entities, who may possess greater financial, marketing or research and development resources than us or may invest more funds in renovating their facilities or developing technology.

If our competitors are better able to attract patients, recruit and retain physicians and other healthcare professionals, expand services or obtain favorable managed care contracts at their facilities, we may experience a decline in patient volume and our results of operations may be adversely affected.

The NHS is the principal provider of mental healthcare services in the United Kingdom, with approximately 70% of the total beds in secure mental healthcare services in the United Kingdom. As the preferred provider, there is often a bias toward referrals to NHS, and therefore NHS facilities have maintained high occupancy rates. As a result of budget constraints, independent operators have emerged to satisfy the demand for mental health services not supplied by the NHS. In addition to the NHS, we face competition in the United Kingdom from independent sector providers and other publicly funded entities for individuals requiring care and for appropriate sites on which to develop or expand facilities in the United Kingdom. Should we fail to compete effectively with our peers and competitors in the industry, or if the competitive environment intensifies, individuals may be referred elsewhere for services that we provide, negatively impacting our ability to secure referrals and limiting the expansion of our business.

The trend by insurance companies and managed care organizations to enter into sole-source contracts may limit our ability to obtain patients.

Insurance companies and managed care organizations in the United States are entering into sole-source contracts with healthcare providers, which could limit our ability to obtain patients since we do not offer the range of services required for these contracts. Moreover, private insurers, managed care organizations and, to a lesser extent, Medicaid and Medicare, are beginning to carve-out specific services, including mental health and substance abuse services, and establish small, specialized networks of providers for such services at fixed reimbursement rates. Continued growth in the use of carve-out arrangements could materially adversely affect our business to the extent we are not selected to participate in such networks or if the reimbursement rate in such networks is not adequate to cover the cost of providing the service.

Our performance depends on our ability to recruit and retain quality psychiatrists and other physicians.

The success and competitive advantage of our facilities depends, in part, on the number and quality of the psychiatrists and other physicians on the medical staffs of our facilities and our maintenance of good relations with those medical professionals. Although we employ psychiatrists and other physicians at many of our facilities, psychiatrists and other physicians generally are not employees of our facilities, and, in a number of our markets, they have admitting privileges at competing hospitals providing acute or inpatient

behavioral healthcare services. Such physicians (including psychiatrists) may terminate their affiliation with us at any time or admit their patients to competing healthcare facilities or hospitals. If we are unable to attract and retain sufficient numbers of quality psychiatrists and other physicians by providing adequate support personnel and facilities that meet the needs of those psychiatrists and other physicians, they may stop referring patients to our facilities and our results of operations may decline.

It may become difficult for us to attract and retain an adequate number of psychiatrists and other physicians to practice in certain of the communities in which our facilities are located. Our failure to recruit psychiatrists and other physicians to these communities or the loss of such medical professionals in these communities could make it more difficult to attract patients to our facilities and thereby may have a material adverse effect on our business, financial condition or results of operations. Additionally, our ability to recruit psychiatrists and other physicians is closely regulated. The form, amount and duration of assistance we can provide to recruited psychiatrists and other physicians is limited by the Stark Law, the Anti-Kickback Statute, state anti-kickback statutes, and related regulations.

Our facilities face competition for staffing that may increase our labor costs and reduce our profitability.

Our operations depend on the efforts, abilities, and experience of our management and medical support personnel, including our addiction counselors, therapists, nurses, pharmacists, licensed counselors, clinical technicians, and mental health technicians, as well as our psychiatrists and other professionals. We compete with other healthcare providers in recruiting and retaining qualified management, program directors, physicians (including psychiatrists) and support personnel responsible for the daily operations of our business, financial condition or results of operations.

With respect to our facilities in the United Kingdom, we compete with various providers, including the NHS and other employers, in attracting and retaining qualified management, medical, nursing, care and teaching personnel. Competition for such employees is growing and could lead to increases in our personnel and recruiting costs, which would in turn adversely impact our operating costs and margins. Competitors, in particular the NHS, may offer more attractive wages, pension plans or other benefits than us and we may not be able to provide similar offerings to our prospective employees as a result of cost or other reasons.

A shortage of nurses, qualified addiction counselors, and other medical support personnel has been a significant operating issue facing us and other healthcare providers. This shortage may require us to enhance wages and benefits to recruit and retain nurses, qualified addiction counselors, and other medical support personnel or require us to hire more expensive temporary or contract personnel. Further, because we generally recruit our personnel from the local area where the relevant facility is located, the availability in certain areas of suitably qualified personnel can be limited, particularly care home management, qualified teaching personnel and nurses. In addition, certain of our facilities are required to maintain specified staffing levels. To the extent we cannot meet those levels, we may be required to limit the services provided by these facilities, which would have a corresponding adverse effect on our net operating revenues. Certain of our treatment facilities are located in remote geographical areas, far from population centers, which increases this risk.

We cannot predict the degree to which we will be affected by the future availability or cost of attracting and retaining talented medical support staff. If our general labor and related expenses increase, we may not be able to raise our rates correspondingly. Our failure either to recruit and retain qualified management, psychiatrists, therapists, counselors, nurses and other medical support personnel or control our labor costs could have a material adverse effect on our results of operations.

Some of our employees are represented by labor unions and any work stoppage could adversely affect our business.

Increased labor union activity could adversely affect our labor costs. As of December 31, 2015, labor unions represented approximately 472 of our employees, at five of our U.S. facilities through eight collective bargaining agreements. The Royal College of Nursing represents nursing employees at all of our facilities in the United Kingdom. We cannot assure you that we will be able to successfully negotiate a satisfactory collective bargaining agreement or that employee relations will remain stable. Furthermore, there is a possibility that work stoppages could occur as a result of union activity, which could increase our labor costs and adversely affect our business, financial condition or results of operations. To the extent that a greater portion of our employee base unionizes and the terms of any collective bargaining agreements are significantly different from our current compensation arrangements, it is possible that our labor costs could increase materially and our business, financial condition or results of operations could be adversely affected.

We depend on key management personnel, and the departure of one or more of our key executives or a significant portion of our local facility management personnel could harm our business.

The expertise and efforts of our senior executives and the chief executive officer, chief financial officer, medical directors, physicians and other key members of our facility management personnel are important to the success of our business. The loss of the services of one or more of our senior executives, including the senior management team of Partnerships in Care or Priory, or of a significant portion of our facility management personnel could significantly undermine our management expertise and our ability to provide efficient, quality healthcare services at our facilities, which could harm our business.

We could face risks associated with, or arising out of, environmental, health and safety laws and regulations.

We are subject to various federal, foreign, state and local laws and regulations that:

- regulate certain activities and operations that may have environmental or health and safety effects, such as the generation, handling and disposal of medical wastes;
- impose liability for costs of cleaning up, and damages to natural resources from, past spills, waste disposals on and off-site, or other releases of hazardous materials or regulated substances; and
- regulate workplace safety.

Compliance with these laws and regulations could increase our costs of operation. Violation of these laws may subject us to significant fines, penalties or disposal costs, which could negatively impact our results of operations, financial condition or cash flows. We could be responsible for the investigation and remediation of environmental conditions at currently or formerly owned, operated or leased sites, as well as for associated liabilities, including liabilities for natural resource damages, third party property damage or personal injury resulting from lawsuits that could be brought by the government or private litigants, relating to our operations, the operations of facilities or the land on which our facilities are located. We may be subject to these liabilities regardless of whether we operate, lease or own the facility, and regardless of whether such environmental conditions were created by us or by a prior owner or tenant, or by a third party or a neighboring facility whose operations may have affected such facility or land. That is because liability for contamination under certain environmental laws can be imposed on current or past owners, lessors or operators of a site without regard to fault. We cannot assure you that environmental conditions relating to our prior, existing or future sites or those of predecessor companies whose liabilities we may have assumed or acquired will not have a material adverse effect on our business, financial condition or results of operations.

State efforts to regulate the construction or expansion of healthcare facilities in the United States could impair our ability to operate and expand our operations.

A majority of the states in which we operate facilities in the United States have enacted certificate of need ("CON"), laws that regulate the construction or expansion of healthcare facilities, certain capital expenditures or changes in services or bed capacity. In giving approval for these actions, these states consider the need for additional or expanded healthcare facilities or services. Our failure to obtain necessary state approval could (i) result in our inability to acquire a targeted facility, complete a desired expansion or make a desired replacement, (ii) make a facility ineligible to receive reimbursement under the Medicare or Medicaid programs or (iii) result in the revocation of a facility's license or impose civil or criminal penalties on us, any of which could harm our business.

In addition, significant CON reforms have been proposed in a number of states that would increase the capital spending thresholds and provide exemptions of various services from review requirements. In the past, we have not experienced any material adverse effects from such requirements, but we cannot predict the impact of these changes upon our operations.

We may be unable to extend leases at expiration, which could harm our business, financial condition or results of operations.

We lease the real property on which a number of our facilities are located. Our lease agreements generally give us the right to renew or extend the term of the leases and, in certain cases, purchase the real property. These renewal and purchase rights generally are based upon either prescribed formulas or fair market value. Management expects to renew, extend or exercise purchase options with respect to our leases in the normal course of business; however, there can be no assurance that these rights will be exercised in the future or that we will be able to satisfy the conditions precedent to exercising any such renewal, extension or purchase options. Furthermore, the terms of any such options that are based on fair market value are inherently uncertain and could be unacceptable or unfavorable to us depending on the circumstances at the time of exercise. If we are not able to renew or extend our existing leases, or purchase the real property subject to such leases, at or prior to the end of the existing lease terms, or if the terms of such options are unfavorable or unacceptable to us, our business, financial condition or results of operations could be adversely affected.

Controls designed to reduce inpatient services may reduce our revenues.

Controls imposed by Medicare, Medicaid and commercial third-party payors designed to reduce admissions and lengths of stay, commonly referred to as "utilization review," have affected and are expected to continue to affect our facilities. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payor-required preadmission authorization and utilization review and by payor pressure to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Efforts to impose more stringent cost controls are expected to continue. For example, the Health Reform Legislation potentially expands the use of prepayment review by Medicare contractors by eliminating statutory restrictions on its use. Utilization review is also a requirement of most non-governmental managed-care organizations and other third party payors. Although we are

unable to predict the effect these controls and changes will have on our operations, significant limits on the scope of services reimbursed and on reimbursement rates and fees could have a material adverse effect on our financial condition and results of operations.

Additionally, the outsourcing of behavioral healthcare to the private sector is a relatively recent development in the United Kingdom. There has been some opposition to outsourcing. While we anticipate that the NHS will continue to rely increasingly upon outsourcing, we cannot assure you that the outsourcing trend will continue. The absence of future growth in the outsourcing of behavioral healthcare services could have a material adverse impact on our business, financial condition and results of operations.

Although we have facilities in 39 states, the United Kingdom and Puerto Rico, we have substantial operations in each of the United Kingdom, Pennsylvania and Arkansas, which makes us especially sensitive to regulatory, economic, environmental and competitive conditions and changes in those locations.

On a pro forma basis for the year ended December 31, 2015, giving effect to the 2014 and 2015 Acquisitions and the Priory acquisition, our revenues in the United Kingdom represented approximately 45% of our total revenue. Arkansas and Pennsylvania represented approximately 6% and 4% of our revenue on a pro forma basis for the year ended December 31, 2015, respectively. This concentration makes us particularly sensitive to legislative, regulatory, economic, environmental and competition changes in those locations. Any material change in the current payment programs or regulatory, economic, environmental or competitive conditions in these locations could have a disproportionate effect on our overall business results. If our facilities in these states are adversely affected by changes in regulatory and economic conditions, our business, financial condition or results of operations could be adversely affected.

In addition, some of our facilities are located in hurricane-prone areas. In the past, hurricanes have had a disruptive effect on the operations of facilities and the patient populations in hurricane-prone areas. Our business activities could be significantly disrupted by a particularly active hurricane season or even a single storm, and our property insurance may not be adequate to cover losses from such storms or other natural disasters.

We are required to treat patients with emergency medical conditions regardless of ability to pay.

In accordance with our internal policies and procedures, as well as EMTALA, we provide a medical screening examination to any individual who comes to one of our hospitals seeking medical treatment (whether or not such individual is eligible for insurance benefits and regardless of ability to pay) to determine if such individual has an emergency medical condition. If it is determined that such person has an emergency medical condition, we provide such further medical examination and treatment as is required to stabilize the patient's medical condition, within the facility's capability, or arrange for the transfer of the individual to another medical facility in accordance with applicable law and the treating hospital's written procedures. Our hospitals may face substantial civil penalties if we fail to provide appropriate screening and stabilizing treatment or fail to facilitate other appropriate transfers as required by EMTALA. Our obligations under EMTALA may increase substantially; CMS has recently sought stakeholder comments concerning the potential applicability of EMTALA to hospital inpatients and the responsibilities of hospitals with specialized capabilities, such as ours, to accept the transfer of such patients. If the number of indigent and charity care patients with emergency medical conditions we treat increases significantly, or if regulations expanding our obligations to inpatients under EMTALA are adopted, our results of operations may be harmed.

An increase in uninsured or underinsured patients or the deterioration in the collectability of the accounts of such patients could harm our results of operations.

Collection of receivables from third-party payors and patients is critical to our operating performance. Our primary collection risks relate to uninsured patients and the portion of the bill that is the patient's responsibility, which primarily includes co-payments and deductibles. We estimate our provisions for doubtful accounts based on general factors such as payor source, the agings of the receivables and historical collection experience. At December 31, 2015, our allowance for doubtful accounts represented approximately 12% of our accounts receivable balance as of such date. We routinely review accounts receivable balances in conjunction with these factors and other economic conditions that might ultimately affect the collectability of the patient accounts and make adjustments to our allowances as warranted. Significant changes in business office operations, payor mix, economic conditions or trends in federal and state governmental health coverage (including implementation of the Health Reform Legislation) could affect our collection of accounts receivable, cash flow and results of operations. If we experience unexpected increases in the growth of uninsured and underinsured patients or in bad debt expenses, our results of operations will be harmed.

Table of Contents

A cyber security incident could cause a violation of HIPAA and other privacy laws and regulations or result in a loss of confidential data.

A cyber-attack that bypasses our information technology ("IT"), security systems causing an IT security breach, loss of PHI or other data subject to privacy laws, loss of proprietary business information, or a material disruption of our IT business systems, could have a material adverse impact on our business, financial condition or results of operations. In addition, our future results of operations, as well as our reputation, could be adversely impacted by theft, destruction, loss, or misappropriation of PHI, other confidential data or proprietary business information.

Failure to maintain effective internal control over financial reporting in accordance with Section 404 of the Sarbanes-Oxley Act of 2002 (the "Sarbanes-Oxley Act"), could have a material adverse effect on our business.

We are required to maintain internal control over financial reporting under Section 404 of the Sarbanes-Oxley Act. If we are unable to maintain adequate internal control over financial reporting, we may be unable to report our financial information on a timely basis, may suffer adverse regulatory consequences or violations of NASDAQ listing rules and may breach the covenants under our financing arrangements. There could also be a negative reaction in the financial markets due to a loss of investor confidence in us and the reliability of our financial statements. If we or our independent registered public accounting firm identify any material weakness in our internal control over financial reporting in the future (including any material weakness in the controls of businesses we have acquired), their correction could require additional remedial measures which could be costly, time-consuming and could have a material adverse effect on our business.

As part of the acquisition of Priory, we assumed Priory's existing pension plans and are responsible for ongoing funding requirements over which we have limited influence. In addition, we may be required to increase funding of these pension plans and/or be subject to restrictions on the use of excess cash.

As a result of the acquisition of Priory, we assumed four defined benefit pension plans and 17 defined contribution pension plans under which we are obligated to make future contributions to fund benefits to participants. The contributions required to fund the defined benefit pension obligations are determined by the plan's actuary based on actuarial valuations, which themselves are based on assumptions and estimates about the long-term operation of the plan, including mortality rates of members, the performance of financial markets and interest rates. In addition, if the actual operation of the plan differs from the actuary's assumptions, additional contributions by us may be required. Benefits under the defined contribution pension plans are based on annual contributions as a proportion of earnings.

Our funding requirements under the defined benefit and defined contribution pension plans for future years are expected to increase from the current levels. Depending on our cash position at the time, any such funding, or contributions to, our pension plans could impact our operating flexibility and financial position, including adversely affecting our cash flow for the quarter in which they are made. In addition, changes to pension legislation in the United Kingdom may adversely affect our funding requirements. Maintenance of these 21 plans may result in additional expenses. Termination of these plans could have an adverse impact on employee relations and a material adverse effect on our business, results of operations, financial condition or prospects.

As part of the Partnerships in Care acquisition, we assumed Partnerships in Care's existing pension plans and a defined contribution plan and are responsible for an underfunded pension liability. In addition, we may be required to increase funding of the pension plans and/or be subject to restrictions on the use of excess cash.

Partnerships in Care is the sponsor of a defined benefit pension plan (the Partnerships in Care Limited Pension and Life Assurance Plan) that covers approximately 187 members in the United Kingdom, most of whom are inactive and retired former employees. In May 2005, this plan was closed to new participants but then-current participants continue to accrue benefits, and effective May 2015, the active participants no longer accrued benefits. As of December 31, 2015, the net deficit recognized under U.S. GAAP in respect of this scheme was £1.9 million.

Future sales of common stock by our existing stockholders may cause our stock price to fall.

The market price of our common stock could decline as a result of sales by our existing stockholders in the market, or the perception that these sales could occur. These sales might also make it more difficult for us to sell equity securities at a time and price that we deem appropriate.

Waud Capital Partners, L.L.C. and certain of its affiliates ("Waud Capital Partners"), investment funds affiliated with Bain Capital Partners, LLC (collectively, "Bain Capital"), along with certain current and former members of our management, and investment funds affiliated with Advent International Corporation ("Advent"), have certain demand and piggyback registration rights with respect to shares of our common stock beneficially owned by them. The presence of additional shares of our common stock trading in the public market, as a result of the exercise of such registration rights, may have an adverse effect on the market price of our securities.

If securities or industry analysts do not publish research or reports about our business, if they were to change their recommendations regarding our stock adversely or if our operating results do not meet their expectations, our stock price and trading volume could decline.

The trading market for our common stock will be influenced by the research and reports that industry or securities analysts publish about us. If one or more of these analysts cease coverage of us or fail to publish regular reports on us, we could lose visibility in the financial markets, which in turn could cause our stock price or trading volume to decline. Moreover, if one or more of the analysts who cover us downgrade our stock or if our operating results do not meet their expectations, our stock price could decline.

We incur substantial costs as a result of being a public company.

As a public company, we incur significant legal, accounting, insurance and other expenses, including costs associated with public company reporting requirements. We incur costs associated with complying with the requirements of the Sarbanes-Oxley Act, the Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Dodd-Frank Act"), and related rules implemented by the SEC and NASDAQ. Enacted in July 2010, the Dodd-Frank Act contains significant corporate governance and executive compensation-related provisions, some of which the SEC has recently implemented by adopting additional rules and regulations in areas such as executive compensation. The expenses incurred by public companies generally for reporting and corporate governance purposes have been increasing. Management expects these laws and regulations to increase our legal and financial compliance costs and to make some activities more time-consuming and costly, although management is currently unable to estimate these costs with any degree of certainty. These laws and regulations could make it more difficult or costly for us to obtain certain types of insurance, including director and officer liability insurance, and we may be forced to accept reduced policy limits and coverage or incur substantially higher costs to obtain the same or similar coverage. These laws and regulations could also make it more difficult for us to attract and retain qualified persons to serve on our board of directors, our board committees or as our executive officers. Furthermore, if we are unable to satisfy our obligations as a public company, we could be subject to delisting of our common stock, fines, sanctions and other regulatory action and potentially civil litigation.

We are party to a stockholders agreement with Waud Capital Partners and Bain Capital, which provides them with certain rights over Company matters.

In accordance with the terms of the Amended and Restated Stockholders Agreement, Waud Capital Partners has the right to designate, following the expiration of the current term of directors designated by Waud Capital Partners, one nominee for election to the board of directors of the Company for one additional three-year term. Waud Capital Partners also retains a consent right over the removal of existing directors designated by Waud Capital Partners and any vacancies in such designated board seats may be filled by Waud Capital Partners prior to the expiration of the current terms of such directors. The merger agreement related to our acquisition of CRC provided that one designee of Bain Capital be appointed to our board of directors as a Class III director at the effective time of the merger.

It is possible that the interests of Waud Capital Partners and Bain Capital may in some circumstances conflict with our interests and the interests of our stockholders.

Provisions of our charter documents or Delaware law could delay or prevent an acquisition of us, even if the acquisition would be beneficial to our stockholders, and could make it more difficult for stockholders to change management.

Provisions of our amended and restated certificate of incorporation and amended and restated bylaws may discourage, delay or prevent a merger, acquisition or other change in control that stockholders may consider favorable, including transactions in which stockholders might otherwise receive a premium for their shares. This is because these provisions may prevent or frustrate attempts by stockholders to replace or remove our management. These provisions include:

- a classified board of directors;
- a prohibition on stockholder action through written consent;
- a requirement that special meetings of stockholders be called only upon a resolution approved by a majority of our directors then in office;
- advance notice requirements for stockholder proposals and nominations; and
- the authority of the board of directors to issue preferred stock with such terms as the board of directors may determine.

Section 203 of the Delaware General Corporation Law ("DGCL") prohibits a publicly-held Delaware corporation from engaging in a business combination with an interested stockholder, generally a person that together with its affiliates owns or within the last three years has owned 15% of voting stock, for a period of three years after the date of the transaction in which the person became an interested stockholder, unless the business combination is approved in a prescribed manner. Although we have elected not to be subject to Section 203 of the DGCL, our amended and restated certificate of incorporation contains provisions that have the same effect as Section 203, except that they provide that Waud Capital Partners, its affiliates and any investment fund managed by Waud Capital Partners and any persons to whom Waud Capital Partners sells at least five percent (5%) of our outstanding voting stock will be deemed to have been approved by our board of directors, and thereby not subject to the restrictions set forth in our amended and restated certificate of incorporation that have the same effect as Section 203 of the DGCL. Accordingly, the provision in our amended and restated certificate of incorporation that adopts a modified version of Section 203 of the DGCL may discourage, delay or prevent a change in control of us.

As a result of these provisions in our charter documents and Delaware law, the price investors may be willing to pay in the future for shares of our common stock may be limited.

We have a very limited number of authorized but unissued shares of common stock, and we may not be able to increase the number of authorized shares of our common stock.

Under our amended and restated certificate of incorporation, we have the authority to issue 90,000,000 shares of common stock. As of December 31, 2015, we had 71,689,268 shares of common stock issued and outstanding, and had an aggregate of 1,926,522 shares reserved for future grants under our Incentive Compensation Plan. We issued 11,500,000 shares of our common stock in a registered public offering that closed on January 12, 2016, As a result of the acquisition of Priory, we issued an additional 4,033,561 to Advent, and we do not have many shares of common stock available for future issuance.

In February 2016, we filed definitive proxy materials with the SEC related to the Company's Special Meeting of the Stockholders to be held on March 3, 2016, where the Company's stockholders will be asked to amend the Company's Amended and Restated Certificate of Incorporation to increase the number of authorized shares of our common stock from 90,000,000 shares to 180,000,000 shares. We cannot provide any assurance that we will be able to obtain the required stockholder approval. If our stockholders do not approve an increase in our authorized common shares, our ability to use our shares to finance acquisitions and to raise additional capital in the future will be limited and, as result, would impair our financial flexibility, including our liquidity needs and our ability to repay our debt obligations when they mature, execute our business plan, make future acquisitions, and fund operations, any of which would have a material adverse effect on our business, results of operations, financial condition or prospects.

We do not anticipate paying any cash dividends in the foreseeable future.

We intend to retain our future earnings, if any, for use in our business or for other corporate purposes and do not anticipate that cash dividends with respect to common stock will be paid in the foreseeable future. Any decision as to the future payment of dividends will depend on our results of operations, financial position and such other factors as our board of directors, in its discretion, deems relevant. In addition, the terms of our debt substantially limit our ability to pay dividends. As a result, capital appreciation, if any, of our common stock will be a stockholder's sole source of gain for the foreseeable future.

Item 1B. Unresolved Staff Comments.

None.

Item 2. Properties.

The following table lists, by state or country, the number of behavioral healthcare facilities directly or indirectly owned and operated by us as of December 31, 2015:

State	Facilities	Operated Beds
Alaska	1	—
Arizona	4	328
Arkansas	6	622
California	22	362
Delaware	2	85
Florida	6	422
Georgia	5	278
Idaho	1	—
Illinois	1	164
Indiana	8	293
Kansas	1	—
Louisiana	6	291
Maine	4	—
Maryland	3	—
Massachusetts	12	120
Michigan	5	291
Mississippi	2	332
Missouri	2	295
Montana	1	108
Nevada	5	104
New Hampshire	2	—
New Jersey	1	—
New Mexico	2	183
North Carolina	10	423
Ohio	2	106
Oklahoma	1	108
Oregon	6	—
Pennsylvania	30	1,197
Rhode Island	2	—
South Carolina	1	42
South Dakota	1	122
Tennessee	4	381
Texas	5	467
Utah	6	125
Vermont	1	—
Virginia	6	176
Washington	6	111
West Virginia	7	—
Wisconsin	13	35
International		
Puerto Rico	1	172
United Kingdom	54	2,214
	258	9,968

See "Business— U.S. Operations" and "Business— U.K. Operations— Description of U.K. Facilities" for a summary description of our U.S. and U.K. facilities that we own and lease. We currently lease approximately 54,000 square feet of office space at 6100 Tower Circle, Franklin, Tennessee, for our corporate headquarters. Our headquarters and facilities are generally well maintained and in good operating condition.

Item 3. Legal Proceedings.

We are, from time to time, subject to various claims and legal actions that arise in the ordinary course of our business, including claims for damages for personal injuries, medical malpractice, breach of contract, tort and employment related claims. In these actions, plaintiffs request a variety of damages, including, in some instances, punitive and other types of damages that may not be covered by insurance. In the opinion of management, we are not currently a party to any proceeding that would have a material adverse effect on our business, financial condition or results of operations.

Item 4. Mine Safety Disclosures

Not applicable.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities. Price Range of Common Stock

Our common stock is listed for trading on The NASDAQ Global Select Market under the symbol "ACHC." The following table sets forth the high and low sales prices per share of our common stock as reported on The NASDAQ Global Select Market for the two most recent fiscal years:

	High	Low
Year ended December 31, 2014:		
First Quarter	$53.87	$44.00
Second Quarter	$49.29	$38.76
Third Quarter	$52.37	$43.45
Fourth Quarter	$66.88	$46.87
Year ended December 31, 2015:		
First Quarter	$73.81	$55.57
Second Quarter	$78.51	$64.91
Third Quarter	$85.62	$58.70
Fourth Quarter	$74.77	$54.41

Stockholders

As of February 25, 2016, there were approximately 381 holders of record of our common stock.

Recent Sales of Unregistered Securities

None, other than as previously reported in connection with the CRC and Priory acquisitions. See "Business— Overview— Acquisitions."

Issuer Purchases of Equity Securities

During the three months ended December 31, 2015, the Company withheld shares of Company common stock to satisfy employee minimum statutory tax withholding obligations payable upon the vesting of restricted stock, as follows:

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs
October 1 – October 31	978	$ 62.02	—	—
November 1 – November 30	—	—	—	—
December 1 – December 31	—	—	—	—
Total	978			

Dividends

We have never declared or paid dividends on our common stock. We currently intend to retain all available funds and any future earnings to fund the development and growth of our business and to repay indebtedness, and therefore we do not anticipate paying any cash dividends in the foreseeable future. Additionally, because we are a holding company, our ability to pay dividends on our common stock is limited by restrictions on the ability of our subsidiaries to pay dividends or make distributions to us, including restrictions under the terms of the agreements governing our indebtedness. Any future determination to pay dividends will be at the discretion of our board of directors, subject to compliance with covenants in current and future agreements governing our indebtedness (including our Amended and Restated Senior Credit Facility and the indenture governing our Senior Notes), and will depend upon our results of operations, financial condition, capital requirements and other factors that our board of directors deems relevant.

Item 6. Selected Financial Data.

The selected financial data presented below for the years ended December 31, 2015, 2014 and 2013, and as of December 31, 2015 and 2014, is derived from our audited consolidated financial statements included elsewhere in this Annual Report on Form 10-K. The selected financial data for the years ended December 31, 2012 and 2011, and as of December 31, 2013, 2012 and 2011, is derived from our audited consolidated financial statements not included herein. The audited financial statements for the periods presented have been reclassified for discontinued operations. The selected consolidated financial data below should be read in conjunction with the "Management's Discussion and Analysis of Financial Condition and Results of Operations" and with our consolidated financial statements and notes thereto included elsewhere in this Annual Report on Form 10-K. The selected financial data presented below does not give effect to our acquisitions prior to the respective date of such acquisitions.

	Year Ended December 31,				
	2015	2014	2013	2012	2011
	(In thousands, except per share data)				
Income Statement Data:					
Revenue before provision for doubtful accounts	$1,829,619	$1,030,784	$ 735,109	$413,850	$219,704
Provision for doubtful accounts	(35,127)	(26,183)	(21,701)	(6,389)	(3,206)
Revenue	1,794,492	1,004,601	713,408	407,461	216,498
Salaries, wages and benefits(1)	973,732	575,412	407,962	239,639	152,609
Professional fees	116,463	52,482	37,171	19,019	8,896
Supplies	80,663	48,422	37,569	19,496	11,349
Rents and leases	32,528	12,201	10,049	7,838	5,576
Other operating expenses	206,746	110,654	80,572	42,777	20,171
Depreciation and amortization	63,550	32,667	17,090	7,982	4,278
Interest expense, net	106,742	48,221	37,250	29,769	9,191
Debt extinguishment costs	10,818	—	9,350	—	—
Gain on foreign currency derivatives	1,926	(15,262)	—	—	—
Sponsor management fees	—	—	—	—	1,347
Transaction-related expenses	36,571	13,650	7,150	8,112	41,547
Income (loss) from continuing operations, before income taxes	164,753	126,154	69,245	32,829	(38,466)
Provision for (benefit from) income taxes(2)	53,388	42,922	25,975	12,325	(5,272)
Income (loss) from continuing operations	111,365	83,232	43,270	20,504	(33,194)
(Loss) income from discontinued operations, net of income taxes	111	(192)	(691)	(101)	(1,698)
Net income (loss)	111,476	83,040	42,579	20,403	(34,892)
Net loss attributable to noncontrolling interests	1,078	—	—	—	—
Net income (loss) attributable to Acadia Healthcare Company, Inc.	$ 112,554	$ 83,040	$ 42,579	$ 20,403	$ (34,892)
Income (loss) from continuing operations per share basic	$ 1.65	$ 1.51	$ 0.87	$ 0.53	$ (1.77)
Income (loss) from continuing operations per share diluted	$ 1.64	$ 1.50	$ 0.86	$ 0.53	$ (1.77)
Balance Sheet Data (as of end of period):					
Cash and cash equivalents	$ 11,215	$ 94,040	$ 4,569	$ 49,399	$ 61,118
Total assets	4,279,208	2,206,955	1,213,623	972,546	402,736
Total debt	2,240,744	1,079,635	606,100	462,451	267,199
Total equity	1,683,028	880,965	480,710	432,550	96,365

(1) Salaries, wages and benefits for the years ended December 31, 2015, 2014, 2013 and 2012 include $20.5 million, $10.1 million, $5.2 million and $2.3 million, respectively, of equity-based compensation expense.

(2) On April 1, 2011, the Company and its wholly-owned limited liability company subsidiaries elected to be taxed as a corporation for federal and state income tax purposes, and, therefore, income taxes became the obligation of the Company subsequent to April 1, 2011.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

You should read the following discussion and analysis of our financial condition and results of operations with our audited consolidated financial statements and notes thereto included elsewhere in this Annual Report on Form 10-K.

Table of Contents

Forward-Looking Statements

This Annual Report on Form 10-K contains "forward-looking statements" within the meaning of the Private Securities Litigation Reform Act of 1995. Forward-looking statements include any statements that address future results or occurrences. In some cases you can identify forward-looking statements by terminology such as "may," "might," "will," "would," "should," "could" or the negative thereof. Generally, the words "anticipate," "believe," "continue," "expect," "intend," "estimate," "project," "plan" and similar expressions identify forward-looking statements. In particular, statements about our expectations, beliefs, plans, objectives, assumptions or future events or performance contained are forward-looking statements.

We have based these forward-looking statements on our current expectations, assumptions, estimates and projections. While we believe these expectations, assumptions, estimates and projections are reasonable, such forward-looking statements are only predictions and involve known and unknown risks, uncertainties and other factors, many of which are outside of our control, which could cause our actual results, performance or achievements to differ materially from any results, performance or achievements expressed or implied by such forward-looking statements. These risks, uncertainties and other factors include, but are not limited to:

- review of our acquisition of Priory by the CMA;
- our significant indebtedness, our ability to meet our debt obligations, and our ability to incur substantially more debt;
- difficulties in successfully integrating the operations of acquired facilities, including those acquired in the Priory and CRC acquisitions, or realizing the potential benefits and synergies of our acquisitions;
- our ability to implement our business strategies in the United Kingdom and adapt to the regulatory and business environment in the United Kingdom;
- the impact of payments received from the government and third-party payors on our revenues and results of operations including the significant dependence of the Priory and Partnerships in Care facilities on payments received from the NHS;
- the occurrence of patient incidents, which could result in negative media coverage, adversely affect the price of our securities and result in incremental regulatory burdens and governmental investigations;
- our future cash flow and earnings;
- our restrictive covenants, which may restrict our business and financing activities;
- our ability to make payments on our financing arrangements;
- the impact of the economic and employment conditions in the United States and the United Kingdom on our business and future results of operations;
- compliance with laws and government regulations;
- the impact of claims brought against our facilities;
- the impact of governmental investigations, regulatory actions and whistleblower lawsuits;
- the impact of healthcare reform in the United States and abroad;
- the impact of our highly competitive industry on patient volumes;
- our ability to recruit and retain quality psychiatrists and other physicians;
- the impact of competition for staffing on our labor costs and profitability;
- our dependence on key management personnel, key executives and local facility management personnel;
- our acquisition strategy, which exposes us to a variety of operational and financial risks, as well as legal and regulatory risks (e.g., exposure to the new regulatory regimes such as the United Kingdom for Priory and Partnerships in Care and various investigations relating to CRC);
- the impact of state efforts to regulate the construction or expansion of healthcare facilities (including those from Priory, CRC and Partnerships in Care) on our ability to operate and expand our operations;
- our potential inability to extend leases at expiration;
- the impact of controls designed to reduce inpatient services on our revenues;
- the impact of different interpretations of accounting principles on our results of operations or financial condition;
- the impact of environmental, health and safety laws and regulations, especially in states where we have concentrated operations;
- the impact of an increase in uninsured and underinsured patients or the deterioration in the collectability of the accounts of such patients on our results of operations;
- the risk of a cyber-security incident and any resulting violation of laws and regulations regarding information privacy or other negative impact;
- the impact of laws and regulations relating to privacy and security of patient health information and standards for electronic transactions;
- the impact of a change in the mix of our earnings, and changes in tax rates and laws generally;
- failure to maintain effective internal control over financial reporting;
- the impact of fluctuations in our operating results, quarter to quarter earnings and other factors on the price of our securities;

- the impact of the trend for insurance companies and managed care organizations to enter into sole source contracts on our ability to obtain patients;

- the impact of fluctuations in foreign exchange rates; and
- those risks and uncertainties described from time to time in our filings with the Securities and Exchange Commission.

Given these risks and uncertainties, you are cautioned not to place undue reliance on such forward-looking statements. These risks and uncertainties may cause our actual future results to be materially different than those expressed in our forward-looking statements. These forward-looking statements are made only as of the date of this Annual Report on Form 10-K. We do not undertake and specifically decline any obligation to update any such statements or to publicly announce the results of any revisions to any such statements to reflect future events or developments.

Overview

Our business strategy is to acquire and develop behavioral healthcare facilities and improve our operating results within our facilities and our other behavioral healthcare operations. We strive to improve the operating results of our facilities by providing high-quality services, expanding referral networks and marketing initiatives while meeting the increased demand for behavioral healthcare services through expansion of our current locations as well as developing new services within existing locations. At December 31, 2015, we operated 258 behavioral healthcare facilities with over 9,900 beds in 39 states, the United Kingdom and Puerto Rico. During the year ended December 31, 2015, we acquired 176 facilities and added approximately 670 new beds, including 460 to existing facilities and 210 in two de novo facilities. For the year ending December 31, 2016, we expect to add approximately 800 total beds exclusive of acquisitions.

We are the leading publicly traded pure-play provider of behavioral healthcare services, with operations in the United States and the United Kingdom. Management believes that the Company's recent acquisitions position the Company as a leading platform in a highly fragmented industry under the direction of an experienced management team that has significant industry expertise. Management expects to take advantage of several strategies that are more accessible as a result of our increased size and geographic scale, including continuing a national marketing strategy to attract new patients and referral sources, increasing our volume of out-of-state referrals, providing a broader range of services to new and existing patients and clients and selectively pursuing opportunities to expand our facility and bed count.

Acquisitions

On February 16, 2016, we completed the acquisition of Priory for a total purchase price of approximately $2.2 billion, including total cash consideration of approximately $1.9 billion and 4,033,561 shares our common stock. Priory is the leading independent provider of behavioral healthcare services in the United Kingdom. At December 31, 2015, Priory operated 327 facilities with approximately 7,100 beds.

On December 1, 2015, we completed the acquisition of certain facilities from MMO, including two acute inpatient behavioral health facilities with a total of 80 beds located in Jennings and Covington, Louisiana, for cash consideration of approximately $20.2 million.

On November 1, 2015, we completed the acquisitions of (i) Discovery House for cash consideration of approximately $118.5 million, (ii) Duffy's for cash consideration of approximately $29.6 million and (iii) Cleveland House for approximately $10.3 million. Discovery House operates 19 comprehensive treatment centers located in four states. Duffy's is a substance abuse facility with 61 beds located in Calistoga, California. Cleveland House is an inpatient psychiatric facility with 32 beds located in England.

On October 1, 2015, we completed the acquisition of Meadow View, an inpatient psychiatric facility with 28 beds located in England, for cash consideration of approximately $6.8 million.

On September 1, 2015, we completed the acquisitions of (i) three facilities from Danshell for approximately $59.8 million, (ii) two facilities from H&SCP for approximately $26.2 million and (iii) Manor Hall for approximately $14.0 million. The inpatient psychiatric facilities acquired from Danshell have an aggregate of 73 beds and are located in England. The inpatient psychiatric facilities acquired from H&SCP have an aggregate of 50 beds and are located in England. Manor Hall has 26 beds and is located in England.

On August 31, 2015, we completed the acquisition of a controlling interest in Southcoast, an inpatient psychiatric facility located in Fairhaven, Massachusetts. We own 75% of the equity interests in the facility.

On July 1, 2015, we completed the acquisition of the assets of Belmont, an inpatient psychiatric facility with 147 beds located in Philadelphia, Pennsylvania for cash consideration of approximately $38.2 million which consists of $35.0 million base purchase price and an estimated working capital settlement of $3.2 million.

On July 1, 2015, we completed the acquisition of The Manor Clinic, a substance abuse facility with 15 beds located in England, for cash consideration of approximately $5.9 million.

On June 1, 2015, we completed the acquisitions of (i) one facility from Choice for approximately $25.9 million and (ii) 15 facilities from Care UK for approximately $88.2 million. The inpatient psychiatric facility acquired from Choice has 42 beds and is located in England. The inpatient psychiatric facilities acquired from Care UK have an aggregate of 299 beds and are located in England.

On April 1, 2015, we completed the acquisitions of (i) two facilities from Choice for approximately $37.5 million, (ii) Pastoral for approximately $34.2 million and (iii) Mildmay Oaks for approximately $14.9 million. The two inpatient psychiatric facilities acquired from Choice have an aggregate of 48 beds and are located in England. Pastoral operates two inpatient psychiatric facilities with an aggregate of 65 beds located in Wales. Mildmay Oaks is an inpatient psychiatric facility with 67 beds located in England.

On March 1, 2015, we acquired the stock of QAM for total consideration of approximately $54.8 million. QAM operates seven comprehensive treatment centers located in Wisconsin.

On February 11, 2015, we completed the acquisition of CRC for total consideration of approximately $1.3 billion. As consideration for the acquisition, we issued 5,975,326 shares of our common stock to certain holders of CRC common stock and repaid CRC's outstanding indebtedness. CRC is a leading provider of treatment services related to substance abuse and other addiction and behavioral disorders. At the acquisition date, CRC operated 35 inpatient facilities with over 2,400 beds and 81 comprehensive treatment centers located in 30 states.

On December 31, 2014, we completed the acquisition of Skyway, a substance abuse facility with 28 beds located in Chico, California, for cash consideration of $0.3 million. On December 1, 2014, we acquired the assets of Croxton, an inpatient psychiatric facility with 24 beds located in England, for cash consideration of $15.6 million. On September 3, 2014, we completed the acquisition of McCallum, an eating disorder treatment facility with 85 beds offering residential, partial hospitalization and intensive outpatient treatment programs located in St. Louis, Missouri, and Austin, Texas, for total consideration of $37.4 million. On July 1, 2014, we acquired Partnerships in Care for cash consideration of $661.7 million, which was net of cash acquired of $12.0 million and the gain on settlement of foreign currency derivatives of $15.3 million. At the acquisition date, Partnerships in Care was the second largest independent provider of inpatient behavioral healthcare services in the United Kingdom, operating 23 inpatient behavioral healthcare facilities with over 1,200 beds. On January 1, 2014, we acquired the assets of Pacific Grove, an inpatient psychiatric facility with 68 beds located in Riverside, California, for cash consideration of $10.5 million.

Revenue

Our revenue is primarily derived from services rendered to patients for inpatient psychiatric and substance abuse care, outpatient psychiatric care and adolescent residential treatment. We receive payments from the following sources for services rendered in our facilities: (i) state governments under their respective Medicaid and other programs; (ii) commercial insurers; (iii) the federal government under the Medicare program administered by CMS; (iv) the NHS (including Local Authorities) in the United Kingdom; and (v) individual patients and clients. Revenue is recorded in the period in which services are provided at established billing rates less contractual adjustments based on amounts reimbursable by Medicare or Medicaid under provisions of cost or prospective reimbursement formulas or amounts due from other third-party payors at contractually determined rates.

Table of Contents

Results of Operations

The following table illustrates our consolidated results of operations from continuing operations for the respective periods shown (dollars in thousands):

	Year Ended December 31,					
	2015		2014		2013	
	Amount	%	Amount	%	Amount	%
Revenue before provision for doubtful accounts	$1,829,619		$1,030,784		$735,109	
Provision for doubtful accounts	(35,127)		(26,183)		(21,701)	
Revenue	1,794,492	100.0%	1,004,601	100.0%	713,408	100.0%
Salaries, wages and benefits	973,732	54.3%	575,412	57.3%	407,962	57.2%
Professional fees	116,463	6.5%	52,482	5.2%	37,171	5.2%
Supplies	80,663	4.5%	48,422	4.8%	37,569	5.3%
Rents and leases	32,528	1.8%	12,201	1.2%	10,049	1.4%
Other operating expenses	206,746	11.5%	110,654	11.0%	80,572	11.3%
Depreciation and amortization	63,550	3.5%	32,667	3.2%	17,090	2.4%
Interest expense, net	106,742	6.0%	48,221	4.8%	37,250	5.2%
Debt extinguishment costs	10,818	0.6%	—	— %	9,350	1.3%
Loss (gain) on foreign currency derivatives	1,926	0.1%	(15,262)	(1.5)%	—	— %
Transaction related expenses	36,571	2.0%	13,650	1.4%	7,150	1.0%
	1,629,739	90.8%	878,447	87.4%	644,163	90.3%
Income from continuing operations, before income taxes	164,753	9.2%	126,154	12.6%	69,245	9.7%
Provision for income taxes	53,388	3.0%	42,922	4.3%	25,975	3.6%
Income from continuing operations	$ 111,365	6.2%	$ 83,232	8.3%	$ 43,270	6.1%

Year Ended December 31, 2015 Compared to the Year Ended December 31, 2014

Revenue before provision for doubtful accounts. Revenue before provision for doubtful accounts increased $798.8 million, or 77.5%, to $1.8 billion for the year ended December 31, 2015 from $1.0 billion for the year ended December 31, 2014. The increase related primarily to revenue generated during the year ended December 31, 2015 from the facilities acquired in our 2014 and 2015 Acquisitions, particularly the acquisition of CRC. Same-facility revenue before provision for doubtful accounts increased by $78.9 million, or 7.8%, for the year ended December 31, 2015 compared to the year ended December 31, 2014, primarily resulting from same-facility growth in patient days of 8.0%. Consistent with the same-facility patient day growth in 2014, the growth in same-facility patient days for the year ended December 31, 2015 compared to the year ended December 31, 2014 resulted from the addition of beds to our existing facilities and ongoing demand for our services.

Provision for doubtful accounts. The provision for doubtful accounts was $35.1 million for the year ended December 31, 2015, or 1.9% of revenue before provision for doubtful accounts, compared to $26.2 million for the year ended December 31, 2014, or 2.5% of revenue before provision for doubtful accounts. The same-facility provision for doubtful accounts was $26.0 million for the year ended December 31, 2015, or 2.4% of revenue before provision for doubtful accounts, compared to $25.6 million for the year ended December 31, 2014, or 2.5% of revenue before provision for doubtful accounts.

Salaries, wages and benefits. Salaries, wages and benefits ("SWB") expense was $973.7 million for the year ended December 31, 2015 compared to $575.4 million for the year ended December 31, 2014, an increase of $398.3 million. SWB expense included $20.5 million and $10.1 million of equity-based compensation expense for the year ended December 31, 2015 and 2014, respectively. Excluding equity-based compensation expense, SWB expense was $953.3 million, or 53.1% of revenue, for the year ended December 31, 2015, compared to $565.4 million, or 56.3% of revenue, for the year ended December 31, 2014. The $387.9 million increase in SWB expense, excluding equity-based compensation expense, was primarily attributable to SWB expense incurred by the facilities acquired in our 2014 and 2015 Acquisitions, particularly the acquisition of CRC. Same-facility SWB expense was $554.0 million for the year ended December 31, 2015, or 52.3% of revenue, compared to $524.4 million for the year ended December 31, 2014, or 53.5% of revenue.

Table of Contents

Professional fees. Professional fees were $116.5 million for the year ended December 31, 2015, or 6.5% of revenue, compared to $52.5 million for the year ended December 31, 2014, or 5.2% of revenue. The $64.0 million increase was primarily attributable to professional fees incurred by the facilities acquired in our 2014 and 2015 Acquisitions, particularly the acquisition of CRC. Same-facility professional fees were $55.1 million for the year ended December 31, 2015, or 5.2% of revenue, compared to $46.2 million, for the year ended December 31, 2014, or 4.7% of revenue.

Supplies. Supplies expense was $80.7 million for the year ended December 31, 2015, or 4.5% of revenue, compared to $48.4 million for the year ended December 31, 2014, or 4.8% of revenue. The $32.3 million increase was primarily attributable to supplies expense incurred by the facilities acquired in our 2014 and 2015 Acquisitions, particularly the acquisition of CRC. Same-facility supplies expense was $48.3 million for the year ended December 31, 2015, or 4.6% of revenue, compared to $47.3 million for the year ended December 31, 2014, or 4.8% of revenue.

Rents and leases. Rents and leases were $32.5 million for the year ended December 31, 2015, or 1.8% of revenue, compared to $12.2 million for the year ended December 31, 2014, or 1.2% of revenue. The $20.3 million increase was primarily attributable to rents and leases incurred by the facilities acquired in our 2014 and 2015 Acquisitions, particularly the acquisition of CRC. Same-facility rents and leases were $11.3 million for the year ended December 31, 2015, or 1.1% of revenue, compared to $11.6 million for the year ended December 31, 2014, or 1.2% of revenue.

Other operating expenses. Other operating expenses consisted primarily of purchased services, utilities, insurance, travel and repairs and maintenance expenses. Other operating expenses were $206.7 million for the year ended December 31, 2015, or 11.5% of revenue, compared to $110.7 million for the year ended December 31, 2014, or 11.0% of revenue. The $96.0 million increase was primarily attributable to other operating expenses incurred by the facilities acquired in our 2014 and 2015 Acquisitions, particularly the acquisition of CRC. Same-facility other operating expenses were $120.2 million for the year ended December 31, 2015, or 11.3% of revenue, compared to $105.8 million for the year ended December 31, 2014, or 10.8% of revenue.

Depreciation and amortization. Depreciation and amortization expense was $63.6 million for the year ended December 31, 2015, or 3.5% of revenue, compared to $32.7 million for the year ended December 31, 2014, or 3.3% of revenue. The increase in depreciation and amortization was attributable to depreciation associated with capital expenditures during 2014 and 2015 and real estate acquired as part of the 2014 and 2015 Acquisitions.

Interest expense. Interest expense was $106.7 million for the year ended December 31, 2015 compared to $48.2 million for the year ended December 31, 2014. The increase in interest expense was primarily a result of borrowings under the Amended and Restated Senior Credit Facility and the issuance of the 5.625% Senior Notes on February 11, 2015 and September 21, 2015.

Loss (gain) on foreign currency derivatives. In connection with the acquisition in the United Kingdom, the Company entered into foreign currency forward contracts during the years ended December 31, 2015 and 2014 in order to fix the exchange rate applicable to the payment of the acquisition purchase prices. Exchange rate changes between the contract date and the settlement date resulted in a loss on foreign currency derivatives of $1.9 million for the year ended December 31, 2015, compared to a gain of $15.3 million for the year ended December 31, 2014.

Debt extinguishment costs. Debt extinguishment costs for the year ended December 31, 2015 represent $7.5 million of cash charges and $3.3 million of non-cash charges recorded in connection with the repayment of $97.5 million of 12.875% Senior Notes.

Transaction-related expenses. Transaction-related expenses were $36.6 million for the year ended December 31, 2015 compared to $13.7 million for the year ended December 31, 2014. Transaction-related expenses represent costs incurred in the respective periods, primarily related to the 2014 and 2015 Acquisitions, as summarized below (in thousands):

	Year Ended December 31,	
	2015	2014
Advisory and financing commitment fees	$ 10,337	$ —
Legal, accounting and other fees	17,768	12,836
Severance and contract termination costs	8,466	814
	$ 36,571	$ 13,650

Provision for income taxes. For the year ended December 31, 2015, the provision for income taxes was $53.4 million, reflecting an effective tax rate of 32.4%, compared to $42.9 million, reflecting an effective tax rate of 34.0%, for 2014. The decrease in the tax rate for the year ended December 31, 2015 was primarily attributable to a full year of results for Partnerships in Care in 2015, compared to six months in 2014, Partnerships in Care is located in a lower taxing jurisdiction and for which earnings are permanently reinvested.

Year Ended December 31, 2014 Compared to the Year Ended December 31, 2013

Revenue before provision for doubtful accounts. Revenue before provision for doubtful accounts increased $295.7 million, or 40.2%, to $1.0 billion for the year ended December 31, 2014 from $735.1 million for the year ended December 31, 2013. The increase related primarily to revenue generated during the year ended December 31, 2014 from the facilities acquired in our 2013 and 2014 Acquisitions, particularly the acquisition of Partnerships in Care. Same-facility revenue before provision for doubtful accounts increased by $79.1 million, or 10.8%, for the year ended December 31, 2014 compared to the year ended December 31, 2013, resulting from same-facility growth in patient days of 10.3% and same-facility revenue per day of 0.6%. Consistent with the same-facility patient day growth in 2013, the growth in same-facility patient days for the year ended December 31, 2014 compared to the year ended December 31, 2013 resulted from the addition of beds to our existing facilities and ongoing demand for our services.

Provision for doubtful accounts. The provision for doubtful accounts was $26.2 million for the year ended December 31, 2014, or 2.5% of revenue before provision for doubtful accounts, compared to $21.7 million for the year ended December 31, 2013, or 3.0% of revenue before provision for doubtful accounts. The same-facility provision for doubtful accounts was $23.3 million for the year ended December 31, 2014, or 2.9% of revenue before provision for doubtful accounts, compared to $21.7 million for the year ended December 31, 2013, or 3.0% of revenue before provision for doubtful accounts.

Salaries, wages and benefits. Salaries, wages and benefits ("SWB") expense was $575.4 million for the year ended December 31, 2014 compared to $408.0 million for the year ended December 31, 2013, an increase of $167.4 million. SWB expense included $10.1 million and $5.2 million of equity-based compensation expense for the year ended December 31, 2014 and 2013, respectively. Excluding equity-based compensation expense, SWB expense was $565.3 million, or 56.3% of revenue, for the year ended December 31, 2014, compared to $402.8 million, or 56.4% of revenue, for the year ended December 31, 2013. The $162.5 million increase in SWB expense, excluding equity-based compensation expense, was primarily attributable to SWB expense incurred by the facilities acquired in our 2013 and 2014 Acquisitions, particularly the acquisition of Partnerships in Care. Same-facility SWB expense was $412.8 million for the year ended December 31, 2014, or 52.4% of revenue, compared to $381.5 million for the year ended December 31, 2013, or 53.7% of revenue.

Professional fees. Professional fees were $52.5 million for the year ended December 31, 2014, or 5.2% of revenue, compared to $37.2 million for the year ended December 31, 2013, or 5.2% of revenue. The $15.3 million increase was primarily attributable to professional fees incurred by the facilities acquired in our 2013 and 2014 Acquisitions, particularly the acquisition of Partnerships in Care. Same-facility professional fees were $34.2 million for the year ended December 31, 2014, or 4.3% of revenue, compared to $31.2 million, for the year ended December 31, 2013, or 4.4% of revenue.

Supplies. Supplies expense was $48.4 million for the year ended December 31, 2014, or 4.8% of revenue, compared to $37.6 million for the year ended December 31, 2013, or 5.3% of revenue. The $10.8 million increase was primarily attributable to supplies expense incurred by the facilities acquired in our 2013 and 2014 Acquisitions, particularly the acquisition of Partnerships in Care. Same-facility supplies expense was $39.5 million for the year ended December 31, 2014, or 5.0% of revenue, compared to $37.4 million for the year ended December 31, 2013, or 5.3% of revenue.

Rents and leases. Rents and leases were $12.2 million for the year ended December 31, 2014, or 1.2% of revenue, compared to $10.0 million for the year ended December 31, 2013, or 1.4% of revenue. The $2.2 million increase was primarily attributable to rents and leases incurred by the facilities acquired in our 2013 and 2014 Acquisitions. Same-facility rents and leases were $10.0 million for the year ended December 31, 2014, or 1.3% of revenue, compared to $9.8 million for the year ended December 31, 2013, or 1.4% of revenue.

Other operating expenses. Other operating expenses consisted primarily of purchased services, utilities, insurance, travel and repairs and maintenance expenses. Other operating expenses were $110.7 million for the year ended December 31, 2014, or 11.0% of revenue, compared to $80.6 million for the year ended December 31, 2013, or 11.3% of revenue. The $30.1 million increase was primarily attributable to other operating expenses incurred by the facilities acquired in our 2013 and 2014 Acquisitions, particularly the acquisition of Partnerships in Care. Same-facility other operating expenses were $86.3 million for the year ended December 31, 2014, or 11.0% of revenue, compared to $78.2 million for the year ended December 31, 2013, or 11.0% of revenue.

Depreciation and amortization. Depreciation and amortization expense was $32.7 million for the year ended December 31, 2014, or 3.7% of revenue, compared to $17.1 million for the year ended December 31, 2013, or 2.4% of revenue. The increase in depreciation and amortization was attributable to depreciation associated with capital expenditures during 2013 and 2014 and real estate acquired as part of the 2013 and 2014 Acquisitions, particularly the acquisition of Partnerships in Care.

Table of Contents

Interest expense. Interest expense was $48.2 million for the year ended December 31, 2014 compared to $37.3 million for the year ended December 31, 2013. The increase in interest expense was primarily a result of the issuance of the 5.125% Senior Notes on July 1, 2014.

Gain on foreign currency derivatives. In connection with the acquisition of Partnerships in Care, the Company entered into foreign currency forward contracts in June 2014 in order to fix the exchange rate applicable to the payment of the purchase price on July 1, 2014. Exchange rate changes between the contract date and the settlement date resulted in a gain on foreign currency derivatives of $15.3 million for the year ended December 31, 2014.

Debt extinguishment costs. Debt extinguishment costs for the year ended December 31, 2013 represent $6.8 million of cash charges and $2.6 million of non-cash charges recorded in connection with the redemption of $52.5 million of the 12.875% Senior Notes.

Transaction-related expenses. Transaction-related expenses were $13.7 million for the year ended December 31, 2014 compared to $7.2 million for the year ended December 31, 2013. Transaction-related expenses represent costs incurred in the respective periods, primarily related to the 2013 and 2014 Acquisitions, as summarized below (in thousands):

	Year Ended December 31,	
	2014	2013
Legal, accounting and other fees	$ 12,836	$ 5,535
Severance and contract termination costs	814	1,615
	$ 13,650	$ 7,150

Provision for income taxes. For the year ended December 31, 2014, the provision for income taxes was $42.9 million, reflecting an effective tax rate of 34.0%, compared to $26.0 million, reflecting an effective tax rate of 37.5%, for 2013. The decrease in the tax rate for the year ended December 31, 2014 was primarily attributable to the acquisition of Partnerships in Care. Partnerships in Care is located in a lower taxing jurisdiction and for which earnings are permanently reinvested.

Liquidity and Capital Resources

Cash provided by continuing operating activities for the year ended December 31, 2015 was $242.1 million compared to $115.5 million for the year ended December 31, 2014. The increase in cash provided by continuing operating activities was primarily attributable to cash provided by continuing operating activities from the 2014 and 2015 Acquisitions and the growth in same-facility operations. Days sales outstanding as of December 31, 2015 was 40 compared to 37 as of December 31, 2014. As of December 31, 2015 and December 31, 2014, we had working capital of $4.5 million and $108.2 million, respectively.

Cash used in investing activities for the year ended December 31, 2015 was $884.5 million compared to $860.8 million for the year ended December 31, 2014. Cash used in investing activities for the year ended December 31, 2015 primarily consisted of $574.8 million of cash paid for acquisitions. Cash paid for capital expenditures for the year ended December 31, 2015 was $276.0 million, consisting of $48.6 million of routine capital expenditures and $227.4 million of expansion capital expenditures. We define expansion capital expenditures as those that increase the capacity of our facilities or otherwise enhance revenue. Routine or maintenance capital expenditures were approximately 3% of revenue for the year ended December 31, 2015. Cash paid for real estate acquisitions was $26.6 million for the year ended December 31, 2015. Cash used in investing activities for the year ended December 31, 2014 primarily consisted of $738.7 million of cash paid for acquisitions, $113.2 million of cash paid for capital expenditures and $23.2 million of cash paid for real estate acquisitions.

Cash provided by financing activities for the year ended December 31, 2015 was $563.6 million compared to $838.0 million for the year ended December 31, 2014. Cash provided by financing activities for the year ended December 31, 2015 primarily consisted of borrowings on long-term debt of $1.2 billion, borrowings on our revolving credit facility of $468.0 million, issuance of common stock of $331.3 million and an excess tax benefit from equity awards of $0.3 million, partially offset by repayment of assumed CRC debt of $904.5 million, principal payments on our revolving credit facility of $310.0 million, repayment of senior notes of $97.5 million, principal payments on long-term debt of $32.0 million, payment of debt issuance costs of $26.4 million, payment of premium for purchase of senior notes of $7.5 million and common stock withheld for minimum statutory taxes of $7.8 million. All of our debt is denominated in U.S. dollars. Cash provided by financing activities for the year ended December 31, 2014 primarily consisted of borrowings on long-term debt instruments of $542.5 million, borrowings on our revolving credit facility of $230.5 million, $374.4 million of proceeds from our issuance of common stock and an excess tax benefit from equity awards of $4.6 million, partially offset by principal payments on our revolving credit facility of $284.0 million, payment of debt issuance costs of $13.0 million, principal payments on long-term debt of $7.7 million, cash paid of $5.0 million as contingent consideration for an acquisition based upon earnings of The Pavilion at HealthPark, LLC ("Park Royal") and common stock withheld for minimum statutory taxes of $4.1 million.

We had total available cash and cash equivalents of $11.2 million, $94.0 million and $4.6 million as of December 31, 2015, 2014 and 2013, respectively, of which approximately $9.2 million, $17.4 million and $3.3 million was held by our foreign subsidiaries, respectively. Our strategic plan does not require the repatriation of foreign cash in order to fund our operations in the U.S., and it is our current intention to permanently reinvest our foreign cash and cash equivalents outside of the U.S. If we were to repatriate foreign cash to the U.S., we would be required to accrue and pay U.S. taxes in accordance with applicable U.S. tax rules and regulations as a result of the repatriation.

Amended and Restated Senior Credit Facility

We entered into the Senior Secured Credit Facility on April 1, 2011. On December 31, 2012, we entered into the Amended and Restated Credit Agreement which amended and restated the Senior Secured Credit Facility.

On February 13, 2014, we entered into the Fourth Amendment to the Amended and Restated Credit Agreement, to increase the size of the Amended and Restated Senior Credit Facility and extend the maturity date thereof, which resulted in the Company having a revolving line of credit of up to $300.0 million and term loans of $300.0 million. The Fourth Amendment also reduced the interest rates applicable to the Amended and Restated Senior Credit Facility and provided increased flexibility to the Company in terms of the financial and other restrictive covenants. The Fourth Amendment also provides for a $150.0 million incremental credit facility, with the potential for unlimited additional incremental amounts, provided the Company meets certain financial ratios, in each case subject to customary conditions precedent to borrowing.

On June 16, 2014, we entered into the Fifth Amendment to the Amended and Restated Senior Credit Facility. The Fifth Amendment specifically permitted the acquisition of Partnerships in Care, gave us the ability to incur a tranche of term loan B debt in the future through its incremental credit facility, and modified certain of the restrictive covenants on miscellaneous investments and incurrence of miscellaneous liens. Finally, the Fifth Amendment provided increased flexibility to the Company in terms of our financial covenants.

On December 15, 2014, we entered into a Sixth Amendment to our Amended and Restated Credit Agreement. Pursuant to the Sixth Amendment, we incurred $235.0 million of additional term loans. A portion of the additional term loan advance was used to prepay our outstanding revolving loans, and a portion of the additional term loan advance was held as cash on our consolidated balance sheet. The Sixth Amendment also specifically permitted the acquisition of CRC. In connection with the acquisition of CRC, the Sixth Amendment (i) imposed a temporary reserve on our revolving credit facility in the amount of $110.0 million in order to preserve such reserved amounts for later borrowings to partially fund the consideration for the acquisition of CRC (subject to limited conditionality provisions) (the reserve is no longer in effect due to the acquisition of CRC), (ii) permitted the incurrence of an additional incremental term loan facility under the Amended and Restated Credit Agreement partially to fund the consideration for the acquisition of CRC (subject to limited conditionality provisions) and (iii) permitted our issuance of additional senior unsecured indebtedness or senior unsecured bridge indebtedness partially to fund the consideration for the acquisition of CRC.

The Sixth Amendment also permits us, subject to certain consents, to add one or more foreign borrowers and/or request revolving loans and letters of credit in foreign currencies.

On February 6, 2015, we entered into the Seventh Amendment to our Amended and Restated Credit Agreement. The Seventh Amendment added Citibank, N.A. as an "L/C Issuer" under the Amended and Restated Credit Agreement in order to permit the rollover of CRC's existing letters of credit into the Amended and Restated Credit Agreement and increased both the Company's Letter of Credit Sublimit and Swing Line Sublimit to $20.0 million.

On February 11, 2015, we entered into the First Incremental Amendment to our Amended and Restated Credit Agreement. The First Incremental Amendment activated a new $500.0 million incremental Existing TLB Facility that was added to the Amended and Restated Senior Secured Credit Facility, subject to limited conditionality provisions. Borrowings under the Existing TLB Facility were used to fund a portion of the purchase price for our acquisition of CRC.

On April 22, 2015, we entered into an Eighth Amendment to our Amended and Restated Credit Agreement. The Eighth Amendment changed the definition of "Change of Control" in part to remove a provision whose purpose was, when calculating whether a majority of incumbent directors have approved new directors, that any incumbent director that became a director as a result of a threatened or actual proxy contest was not counted in such calculation.

On January 25, 2016, we entered into the Ninth Amendment to the Amended and Restated Senior Credit Facility. The Ninth Amendment modifies certain definitions and provides increased flexibility to us in terms of our financial covenants. Our baskets for permitted investments were also increased to provide increased flexibility for us to invest in non-wholly owned subsidiaries, joint ventures and foreign subsidiaries. We may now invest in non-wholly owned subsidiaries and joint ventures up to 10.0% of our and our subsidiaries' total assets in any consecutive four fiscal quarter period, and up to 12.5% of our and our subsidiaries' total assets during the term of the Amended and Restated Credit Agreement. We may also invest in foreign subsidiaries that are not loan parties up to 10% of our and our subsidiaries' total assets in any consecutive four fiscal quarter period, and up to 15% of our and our subsidiaries' total assets during the term of the Amended and Restated Credit Agreement. The foregoing permitted investments are subject to an aggregate cap of 25% of our and our subsidiaries' total assets in any fiscal year.

On February 16, 2016, we entered into the Second Incremental Facility Amendment to our Amended and Restated Credit Agreement. The Second Incremental Amendment activated a new $955.0 million incremental Term Loan B facility and added $135.0 million to the Term Loan A facility to our Amended and Restated Senior Secured Credit Facility, subject to limited conditionality provisions. Borrowings under the New TLB Facility were used to fund a portion of the purchase price for the acquisition of Priory and the fees and expenses for such acquisition and the related financing transactions. Borrowings under the TLA Facility were used to pay down the majority of our $300.0 million revolving credit facility.

We had $135.7 million of availability under the revolving line of credit as of December 31, 2015. Borrowings under the revolving line of credit are subject to customary conditions precedent to borrowing. The Amended and Restated Credit Agreement requires quarterly term loan principal repayments of our TLA Facility of $10.0 million for March 31, 2016 to December 31, 2016, $13.4 million for March 31, 2017 to December 31, 2017, and $16.7 million for March 31, 2018 to December 31, 2018, with the remaining principal balance of the TLA Facility due on the maturity date of February 13, 2019. On December 15, 2014, prior to the execution of the Sixth Amendment, we prepaid the December 31, 2014 quarterly TLA Facility principal payment of $1.9 million. We are required to repay the Existing TLB Facility in equal quarterly installments of $1.3 million on the last business day of each March, June, September and December, with the outstanding principal balance of the Existing TLB Facility due on February 11, 2022. We are required to repay the New TLB Facility in equal quarterly installments of approximately $2.4 million on the last business day of each March, June, September and December, with the outstanding principal balance of the New TLB Facility due on February 16, 2023.

Borrowings under the Amended and Restated Credit Agreement are guaranteed by each of our wholly-owned domestic subsidiaries (other than certain excluded subsidiaries) and are secured by a lien on substantially all of our and such subsidiaries' assets. Borrowings with respect to the TLA Facility and our revolving credit facility (collectively, "Pro Rata Facilities") under the Amended and Restated Credit Agreement bear interest at a rate tied to Acadia's Consolidated Leverage Ratio (defined as consolidated funded debt net of up to $40.0 million of unrestricted and unencumbered cash to consolidated EBITDA, in each case as defined in the Amended and Restated Credit Agreement). The Applicable Rate (as defined in the Amended and Restated Credit Agreement) for the Pro Rata Facilities was 3.0% for Eurodollar Rate Loans (as defined in the Amended and Restated Credit Agreement) and 2.0% for Base Rate Loans (as defined in the Amended and Restated Credit Agreement) at December 31, 2015. Eurodollar Rate Loans with respect to the Pro Rata Facilities bear interest at the Applicable Rate plus the Eurodollar Rate (as defined in the Amended and Restated Credit Agreement) (based upon the LIBOR Rate (as defined in the Amended and Restated Credit Agreement) prior to commencement of the interest rate period). Base Rate Loans with respect to the Pro Rata Facilities bear interest at the Applicable Rate plus the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate and (iii) the Eurodollar Rate plus 1.0%. As of December 31, 2015, the Pro Rata Facilities bore interest at a rate of LIBOR plus 3.0%. In addition, we are required to pay a commitment fee on undrawn amounts under our revolving credit facility.

The interest rates and the unused line fee on unused commitments related to the Pro Rata Facilities are based upon the following pricing tiers:

Pricing Tier	Consolidated Leverage Ratio	Eurodollar Rate Loans	Base Rate Loans	Commitment Fee
1	< 3.50:1.0	2.25%	1.25%	0.30%
2	>3.50:1.0 but < 4.00:1.0	2.50%	1.50%	0.35%
3	>4.00:1.0 but < 4.50:1.0	2.75%	1.75%	0.40%
4	>4.50:1.0 but < 5.25:1.0	3.00%	2.00%	0.45%
5	>5.25:1.0	3.25%	2.25%	0.50%

Eurodollar Rate Loans with respect to the Existing TLB Facility bear interest at the Existing TLB Applicable Rate (as defined below) plus the Eurodollar Rate (subject to a floor of 0.75% and based upon the LIBOR Rate prior to commencement of the interest rate period). Base Rate Loans bear interest at the Existing TLB Applicable Rate plus the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate and (iii) the Eurodollar Rate plus 1.0%. As used herein, the term "Existing TLB Applicable Rate" means, with respect to Eurodollar Rate Loans, 3.50%, and with respect to Base Rate Loans, 2.50%. The New TLB Facility bears interest as

follows: Eurodollar Rate Loans bear interest at the Applicable Rate (as defined in the Amended and Restated Credit Agreement) plus the Eurodollar Rate (subject to a floor of 0.75% and based upon the LIBOR Rate prior to commencement of the interest rate period) and Base Rate Loans bear interest at the Applicable Rate plus the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate and (iii) the Eurodollar Rate plus 1.0%. As used herein, the term "Applicable Rate" means, with respect to Eurodollar Rate Loans, 3.75%, and with respect to Base Rate Loans, 2.75%.

The lenders who provided the Existing TLB Facility and New TLB Facility are not entitled to benefit from the Company's maintenance of its financial covenants under the Amended and Restated Credit Agreement. Accordingly, if we fail to maintain its financial covenants, such failure shall not constitute an event of default under the Amended and Restated Credit Agreement with respect to the Existing TLB Facility or the New TLB Facility until and unless the Amended and Restated Senior Credit Facility is accelerated or the commitment of the lenders to make further loans is terminated.

The Amended and Restated Credit Agreement requires us and our subsidiaries to comply with customary affirmative, negative and financial covenants, including a fixed charge coverage ratio, consolidated leverage ratio and consolidated senior secured leverage ratio. We may be required to pay all of our indebtedness immediately if we default on any of the numerous financial or other restrictive covenants contained in any of its material debt agreements. We may be required to pay all of our indebtedness immediately if we default on any of the numerous financial or other restrictive covenants contained in any of our material debt agreements. Set forth below is a brief description of such covenants, all of which are subject to customary exceptions, materiality thresholds and qualifications:

a) the affirmative covenants include the following: (i) delivery of financial statements and other customary financial information; (ii) notices of events of default and other material events; (iii) maintenance of existence, ability to conduct business, properties, insurance and books and records; (iv) payment of taxes; (v) lender inspection rights; (vi) compliance with laws; (vii) use of proceeds; (viii) further assurances; and (ix) additional collateral and guarantor requirements.

b) the negative covenants include limitations on the following: (i) liens; (ii) debt (including guaranties); (iii) investments; (iv) fundamental changes (including mergers, consolidations and liquidations); (v) dispositions; (vi) sale leasebacks; (vii) affiliate transactions; (viii) burdensome agreements; (ix) restricted payments; (x) use of proceeds; (xi) ownership of subsidiaries; (xii) changes to line of business; (xiii) changes to organizational documents, legal name, state of formation, form of entity and fiscal year; (xiv) prepayment or redemption of certain senior unsecured debt; and (xv) amendments to certain material agreements. The Company is generally not permitted to issue dividends or distributions other than with respect to the following: (w) certain tax distributions; (x) the repurchase of equity held by employees, officers or directors upon the occurrence of death, disability or termination subject to cap of $500,000 in any fiscal year and compliance with certain other conditions; (y) in the form of capital stock; and (z) scheduled payments of deferred purchase price, working capital adjustments and similar payments pursuant to the merger agreement or any permitted acquisition.

c) The financial covenants include maintenance of the following:

- the fixed charge coverage ratio may not be less than 1.25:1.00 as of the end of any fiscal quarter;
- the total leverage ratio may not be greater than the following levels as of the end of each fiscal quarter listed below:

	March 31	June 30	September 30	December 31
2015	N/A	N/A	6.50x	6.00x
2016	6.75x	6.75x	6.75x	6.25x
2017	6.00x	6.00x	6.00x	5.50x
2018	5.50x	5.50x	5.50x	5.00x

- the secured leverage ratio may not be greater than the following levels as of the end of each fiscal quarter listed below:

December 31, 2015- September 30, 2016	3.75x
December 31, 2016 and each fiscal quarter thereafter	3.50x

As of December 31, 2015, the Company was in compliance with all of the above covenants.

Senior Notes

12.875% Senior Notes due 2018

On November 1, 2011, we issued $150.0 million of 12.875% Senior Notes due 2018 at 98.323% of the aggregate principal amount of $150.0 million, a discount of $2.5 million. The notes bear interest at a rate of 12.875% per annum. We pay interest on the notes semi-annually, in arrears, on November 1 and May 1 of each year.

On March 12, 2013, we redeemed $52.5 million in principal amount of the 12.875% Senior Notes using a portion of the net proceeds of our December 2012 equity offering pursuant to the provision in the indenture permitting an optional redemption with equity proceeds of up to 35% of the principal amount of 12.875% Senior Notes. The 12.875% Senior Notes were redeemed at a redemption price of 112.875% of the principal amount thereof plus accrued and unpaid interest to, but not including, the redemption date in accordance with the provisions of the indenture governing the 12.875% Senior Notes. As part of the redemption of 35% of the 12.875% Senior Notes, we recorded a debt extinguishment charge of $9.4 million, including the premium and write-off of deferred financing costs, which was recorded in debt extinguishment costs in the accompanying consolidated statements of income.

On September 21, 2015, we purchased approximately $88.3 million aggregate principal amount of 12.875% Senior Notes in connection with a tender offer for any and all of the 12.875% Senior Notes. The notes purchased represented 90.6% of the outstanding $97.5 million principal amount of 12.875% Senior Notes. The 12.875% Senior Notes were purchased at a price of 107.875% of the principal amount thereof plus accrued and unpaid interest to, but not including, September 21, 2015. On September 18, 2015, we delivered a notice to redeem all $9.2 million in principal amount of the 12.875% Senior Notes remaining outstanding following the consummation of the tender offer. The redemption was effective November 1, 2015 with payment made to the note holders on November 2, 2015. We redeemed the remaining 12.875% Senior Notes in accordance to their terms, and therefore no debt remains outstanding under the 12.875% Senior Notes. In connection with the purchase of notes, the Company recorded a debt extinguishment charge of approximately $10.8 million for the year ended December 31, 2015, including the premium and write-off of deferred financing costs, which was recorded in debt extinguishment costs in the accompanying consolidated statements of income.

6.125% Senior Notes Due 2021

On March 12, 2013, we issued $150.0 million of 6.125% Senior Notes due 2021. The 6.125% Senior Notes mature on March 15, 2021 and bear interest at a rate of 6.125% per annum, payable semi-annually in arrears on March 15 and September 15 of each year.

5.125% Senior Notes due 2022

On July 1, 2014, we issued $300.0 million of 5.125% Senior Notes due 2022. The 5.125% Senior Notes mature on July 1, 2022 and bear interest at a rate of 5.125% per annum, payable semi-annually in arrears on January 1 and July 1 of each year, beginning on January 1, 2015.

5.625% Senior Notes due 2023

On February 11, 2015, we issued $375.0 million of 5.625% Senior Notes due 2023. The 5.625% Senior Notes mature on February 15, 2023 and bear interest at a rate of 5.625% per annum, payable semi-annually in arrears on February 15 and August 15 of each year, beginning on August 15, 2015.

On September 21, 2015, we issued $275.0 million of additional 5.625% Senior Notes. The additional notes form a single class of debt securities with the existing 5.625% Senior Notes. Giving effect to this issuance, we have outstanding an aggregate of $650.0 million of 5.625% Senior Notes.

6.500% Senior Notes due 2024

On February 16, 2016, we issued $390.0 million of 6.500% Senior Notes due 2024. The 6.500% Senior Notes mature on March 1, 2024 and bear interest at a rate of 6.500% per annum, payable semi-annually in arrears on March 1 and September 1 of each year, beginning on September 1, 2016.

The indentures governing the 6.125% Senior Notes, 5.125% Senior Notes, 5.625% Senior Notes and 6.500% Senior Notes (together, the "Senior Notes") contain covenants that, among other things, limit the Company's ability and the ability of its restricted subsidiaries to: (i) pay dividends, redeem stock or make other distributions or investments; (ii) incur additional debt or issue certain preferred stock; (iii) transfer or sell assets; (iv) engage in certain transactions with affiliates; (v) create restrictions on dividends or other payments by the restricted subsidiaries; (vi) merge, consolidate or sell substantially all of the Company's assets; and (vii) create liens on assets.

The Senior Notes issued by the Company are guaranteed by each of the Company's subsidiaries that guarantee the Company's obligations under the Amended and Restated Senior Credit Facility. The guarantees are full and unconditional and joint and several.

The Company may redeem the Senior Notes at its option, in whole or part, at the dates and amounts set forth in the indentures.

9.0% and 9.5% Revenue Bonds

On November 11, 2012, in connection with the acquisition of Park Royal, we assumed debt of $23.0 million. The fair market value of the debt assumed was $25.6 million and resulted in a debt premium balance being recorded as of the acquisition date. The debt consisted of $7.5 million and $15.5 million of Lee County (Florida) Industrial Development Authority Healthcare Facilities Revenue Bonds, Series 2010 with stated interest rates of 9.0% and 9.5%, respectively. The 9.0% bonds in the amount of $7.5 million have a maturity date of December 1, 2030 and require yearly principal payments beginning in 2013. The 9.5% bonds in the amount of $15.5 million have a maturity date of December 1, 2040 and require yearly principal payments beginning in 2031. The principal payments establish a bond-sinking fund to be held with the trustee and shall be sufficient to redeem the principal amounts of the 9.0% and 9.5% Revenue Bonds on their respective maturity dates. As of December 31, 2015 and 2014, $2.3 million was recorded within other assets on the balance sheet related to the debt service reserve fund requirements. The yearly principal payments, which establish a bond sinking fund, will increase the debt service reserve fund requirements. The bond premium amount of $2.6 million is amortized as a reduction of interest expense over the life of the 9.0% and 9.5% Revenue Bonds using the effective interest method.

Contractual Obligations

The following table presents a summary of contractual obligations (dollars in thousands):

	Payments Due by Period				
	Less Than 1 Year	1-3 Years	3-5 Years	More Than 5 Years	Total
Long-term debt (a)	$238,137	$518,144	$766,811	$3,234,141	$4,757,233
Operating leases	29,229	42,188	25,267	56,522	153,206
Purchase and other obligations (b)	1,848	2,810	1,905	29,065	35,628
Total obligations and commitments	$269,214	$563,142	$793,983	$3,319,728	$4,946,067

(a) Amounts include required principal and interest payments as of February 25, 2016, including the borrowings on February 16, 2016 in connection with the Priory acquisition of $955.0 million under our New TLB facility, $390.0 million of 6.500% Senior Notes and $135.0 million under our TLA Facility. The projected interest payments reflect the interest rates in place on our variable-rate debt at December 31, 2015.

(b) Amounts relate to purchase obligations, including capital lease payments.

Off-Balance Sheet Arrangements

As of December 31, 2015, we had standby letters of credit outstanding of $6.3 million related to security for the payment of claims as required by our workers' compensation insurance program.

Market Risk

Our interest expense is sensitive to changes in market interest rates. With respect to our interest-bearing liabilities, our long-term debt outstanding at December 31, 2015 was composed of $1.1 billion of fixed-rate debt and $1.1 billion of variable-rate debt with interest based on LIBOR plus an applicable margin. A hypothetical 10% increase in interest rates would decrease our net income and cash flows by $3.3 million on an annual basis based upon our borrowing level at December 31, 2015.

The functional currency for our U.K. facilities is the British pound ("GBP"). Our revenue and earnings are sensitive to changes in the GBP to USD exchange rate. As a result, our future earnings could be affected by fluctuations in the exchange rate between the U.S. dollar and GBPs. Based upon the level of our U.K. operations relative to the Company as a whole, a hypothetical 10% change in this exchange rate would cause a change in our net income of $5.6 million for the year ended December 31, 2015.

Critical Accounting Policies

Our consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States. In preparing our financial statements, we are required to make estimates and assumptions that affect the reported

amounts of assets, liabilities, revenues, and expenses included in the financial statements. Estimates are based on historical experience and other available information, the results of which form the basis of such estimates. While management believes our estimation processes are reasonable, actual results could differ from our estimates. The following accounting policies are considered critical to the portrayal of our financial condition and operating performance and involve highly subjective and complex assumptions and assessments:

Revenue and Accounts Receivable

Our revenue is primarily derived from services rendered to patients for inpatient psychiatric and substance abuse care, outpatient psychiatric care and adolescent residential treatment. We receive payments from the following sources for services rendered in our facilities: (i) state governments under their respective Medicaid and other programs; (ii) commercial insurers; (iii) the federal government under the Medicare program administered by CMS; (iv) the NHS (including Local Authorities) in the United Kingdom; and (v) individual patients and clients. Revenue is recorded in the period in which services are provided at established billing rates less contractual adjustments based on amounts reimbursable by Medicare or Medicaid under provisions of cost or prospective reimbursement formulas or amounts due from other third-party payors at contractually determined rates.

The following table presents revenue by payor type and as a percentage of revenue before provision for doubtful accounts for the years ended December 31, 2015, 2014 and 2013 (in thousands):

	Year Ended December 31,					
	2015		2014		2013	
	Amount	%	Amount	%	Amount	%
Commercial	$ 423,077	23.1%	$ 237,041	23.0%	$182,915	24.9%
Medicare	214,125	11.7%	200,306	19.4%	158,111	21.5%
Medicaid	609,805	33.3%	395,146	38.3%	353,145	48.0%
NHS	356,965	19.5%	149,156	14.5%	—	— %
Self-Pay	174,850	9.6%	25,166	2.5%	25,153	3.4%
Other	50,797	2.8%	23,969	2.3%	15,785	2.2%
Revenue before provision for doubtful accounts	1,829,619	100.0%	1,030,784	100.0%	735,109	100.0%
Provision for doubtful accounts	(35,127)		(26,183)		(21,701)	
Revenue	$1,794,492		$1,004,601		$713,408	

The following tables present a summary of our aging of accounts receivable as of December 31, 2015 and 2014:

December 31, 2015

	Current	30-90	90-150	>150	Total
Commercial	16.6%	9.1%	3.2%	3.0%	31.9%
Medicare	12.6%	2.3%	1.2%	0.4%	16.5%
Medicaid	23.4%	6.7%	2.8%	4.2%	37.1%
NHS	1.6%	3.1%	0.5%	— %	5.2%
Self-Pay	1.7%	1.8%	2.0%	3.0%	8.5%
Other	0.5%	0.1%	0.1%	0.1%	0.8%
Total	56.4%	23.1%	9.8%	10.7%	100.0%

December 31, 2014

	Current	30-90	90-150	>150	Total
Commercial	14.5%	6.7%	2.6%	3.1%	26.9%
Medicare	15.8%	3.4%	1.7%	3.7%	24.6%
Medicaid	22.2%	4.9%	2.3%	2.8%	32.2%
NHS	2.1%	1.8%	0.1%	—%	4.0%
Self-Pay	1.1%	1.8%	2.2%	6.2%	11.3%
Other	0.3%	0.2%	0.2%	0.3%	1.0%
Total	56.0%	18.8%	9.1%	16.1%	100.0%

Medicaid accounts receivable as of December 31, 2015 and 2014 included approximately $1.1 million and $0.6 million, respectively, of accounts pending Medicaid approval.

Allowance for Contractual Discounts

We derive a significant portion of our revenues from Medicare, Medicaid and other payors that receive discounts from established billing rates. The Medicare and Medicaid regulations and various managed care contracts under which these discounts must be calculated are complex, subject to interpretation and adjustment, and may include multiple reimbursement mechanisms for different types of services provided in our inpatient facilities and cost settlement provisions. Management estimates the allowance for contractual discounts on a payor-specific basis given its interpretation of the applicable regulations or contract terms. The services authorized and provided and related reimbursement are often subject to interpretation that could result in payments that differ from our estimates. Additionally, updated regulations and contract renegotiations occur frequently, necessitating regular review and assessment of the estimation process by management.

Settlements under cost reimbursement agreements with third-party payors are estimated and recorded in the period in which the related services are rendered and are adjusted in future periods as final settlements are determined. Final determination of amounts earned under the Medicare and Medicaid programs often occurs in subsequent years because of audits by such programs, rights of appeal and the application of numerous technical provisions. In the opinion of management, adequate provision has been made for any adjustments and final settlements. However, there can be no assurance that any such adjustments and final settlements will not have a material effect on our financial condition or results of operations. Our cost report receivables were $4.2 million and $1.9 million at December 31, 2015 and 2014, respectively, and were included in other current assets in the consolidated balance sheets. Management believes that these receivables are properly stated and are not likely to be settled for a significantly different amount. The net adjustments to estimated cost report settlements resulted in increases to revenue of $1.9 million, $0.3 million and $0.2 million for the years ended December 31, 2015, 2014 and 2013, respectively.

Management believes that we are in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of wrongdoing. While no such regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs.

Allowance for Doubtful Accounts

Our ability to collect outstanding patient receivables from third party payors is critical to our operating performance and cash flows. The primary collection risk with regard to patient receivables relates to uninsured patient accounts or patient accounts for which primary insurance has paid, but the portion owed by the patient remains outstanding. We estimate uncollectible accounts and establish an allowance for doubtful accounts in order to adjust accounts receivable to estimated net realizable value. In evaluating the collectability of accounts receivable, we consider a number of factors, including the age of the accounts, historical collection experience, current economic conditions, and other relevant factors. Accounts receivable that are determined to be uncollectible based on our policies are written off to the allowance for doubtful accounts. Significant changes in payor mix or business office operations could have a significant impact on our results of operations and cash flows.

Insurance

We are subject to medical malpractice and other lawsuits due to the nature of the services we provide. Our operations have professional and general liability insurance for claims in excess of a $1,000,000 self-insured retention with an insured excess limit of $50 million. The reserve for professional and general liability risks was estimated based on historical claims, demographic factors, industry trends, severity factors, and other actuarial assumptions. The estimated accrual for professional and general liabilities could be significantly affected should current and future occurrences differ from historical claim trends and expectations. While claims are monitored closely when estimating professional and general liability accruals, the complexity of the claims and wide range of potential outcomes often hampers timely adjustments to the assumptions used in these estimates. The professional and general liability

reserve was $41.9 million as of December 31, 2015, of which $10.5 million was included in other accrued liabilities and $31.4 million was included in other long-term liabilities. The professional and general liability reserve was $16.3 million as of December 31, 2014, of which $4.2 million was included in other accrued liabilities and $12.1 million was included in other long-term liabilities. We estimate receivables for the portion of professional and general liability reserves that are recoverable under our insurance policies. Such receivable was $21.3 million as of December 31, 2015, of which $5.3 million was included in other current assets and $16.0 million was included in other assets, and such receivable was $12.0 million as of December 31, 2014, of which $3.5 million was included in other current assets and $8.5 million was included in other assets.

Our statutory workers' compensation program is fully insured with a $500,000 deductible per accident. The workers' compensation liability was $14.7 million as of December 31, 2015, of which $7.5 million was included in accrued salaries and benefits and $7.2 million was included in other long-term liabilities, and such liability was $8.4 million as of December 31, 2014, of which $4.8 million was included in accrued salaries and benefits and $3.6 million was included in other long-term liabilities. The reserve for workers compensation claims was based upon independent actuarial estimates of future amounts that will be paid to claimants. Management believes that adequate provisions have been made for workers' compensation and professional and general liability risk exposures.

Property and Equipment and Other Long-Lived Assets

Property and equipment are recorded at cost. Depreciation is calculated on the straight-line basis over the estimated useful lives of the assets, which typically range from 10 to 50 years for buildings and improvements, three to seven years for equipment and the shorter of the lease term or estimated useful lives for leasehold improvements. When assets are sold or retired, the corresponding cost and accumulated depreciation are removed from the related accounts and any gain or loss is recorded in the period of sale or retirement. Repair and maintenance costs are expensed as incurred. Depreciation expense was $63.0 million, $32.1 million and $16.3 million for the years ended December 31, 2015, 2014 and 2013, respectively.

The carrying values of long-lived assets are reviewed for possible impairment whenever events, circumstances or operating results indicate that the carrying amount of an asset may not be recoverable. If this review indicates that the asset will not be recoverable, as determined based upon the undiscounted cash flows of the operating asset over the remaining useful lives, the carrying value of the asset will be reduced to its estimated fair value. Fair value estimates are based on independent appraisals, market values of comparable assets or internal evaluations of future net cash flows.

Goodwill and Indefinite-Lived Intangible Assets

Our goodwill and other indefinite-lived intangible assets, which consist of licenses and accreditations and certificates of need intangible assets that are not amortized, are evaluated for impairment annually during the fourth quarter or more frequently if events indicate that the carrying value of a reporting unit may not be recoverable. We have two operating segments, U.S. Facilities and U.K. Facilities, for segment reporting purposes, each of which represents a reporting unit for purposes of the Company's goodwill impairment test. Potential impairment is noted for a reporting unit if its carrying value exceeds the fair value of the reporting unit. For a reporting unit with potential impairment of goodwill, we determine the implied fair value of goodwill. If the carrying value of goodwill exceeds its implied fair value, an impairment loss is recorded. Our annual impairment tests of goodwill and other indefinite-lived intangibles in 2015, 2014 and 2013 resulted in no impairment charges.

Income Taxes

We use the asset and liability method of accounting for income taxes. Under this method, deferred income taxes reflect the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes and net operating loss and tax credit carry forwards. The amount of deferred taxes on these temporary differences is determined using the tax rates that are expected to apply to the period when the asset is realized or the liability is settled, as applicable, based on tax rates and laws in the respective tax jurisdiction enacted as of the balance sheet date.

We review our deferred tax assets for recoverability and establish a valuation allowance based on historical taxable income, projected future taxable income, applicable tax strategies, and the expected timing of the reversals of existing temporary differences. A valuation allowance is provided when it is more likely than not that some portion or all of the deferred tax assets will not be realized.

We report a liability for unrecognized tax benefits resulting from uncertain tax positions taken or expected to be taken in a tax return. We recognize interest and penalties, if any, related to unrecognized tax benefits in income tax expense.

We also have accruals for taxes and associated interest that may become payable in future years as a result of audits by tax authorities. We accrue for tax contingencies when it is more likely than not that a liability to a taxing authority has been incurred and the amount of the contingency can be reasonably estimated. Although we believe that the positions taken on previously filed tax

returns are reasonable, we nevertheless have established tax and interest reserves in recognition that various taxing authorities may challenge the positions taken by us resulting in additional liabilities for taxes and interest. These amounts are reviewed as circumstances warrant and adjusted as events occur that affect our potential liability for additional taxes, such as lapsing of applicable statutes of limitations, conclusion of tax audits, additional exposure based on current calculations, identification of new issues, release of administrative guidance, or rendering of a court decision affecting a particular tax issue.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

Information with respect to this Item is provided under the caption "Market Risk" under "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations."

Item 8. Financial Statements and Supplementary Data.

Information with respect to this Item is contained in our consolidated financial statements beginning on Page F-1 of this Annual Report on Form 10-K.

Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure.

None.

Item 9A. Controls and Procedures.

Evaluation of Disclosure Controls and Procedures

As of the end of the period covered by this report, our management conducted an evaluation, with the participation of our chief executive officer and chief financial officer, of the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act")). Based on this evaluation, our chief executive officer and chief financial officer have concluded that our disclosure controls and procedures are effective to ensure that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in Securities and Exchange Commission's rules and forms and that such information is accumulated and communicated to management, including our chief executive officer and chief financial officer, as appropriate to allow timely decisions regarding required disclosure.

Reports on Internal Control Over Financial Reporting

Pursuant to Section 404 of the Sarbanes-Oxley Act of 2002, we have included a report of management's assessment of the design and operating effectiveness of our internal controls as part of this report. Our independent registered public accounting firm also reported on the effectiveness of internal control over financial reporting. Management's report and the independent registered public accounting firm's report are included in our consolidated financial statements beginning on page F-1 of this report under the captions entitled "Management's Report on Internal Control Over Financial Reporting" and "Report of Independent Registered Public Accounting Firm."

Changes in Internal Control Over Financial Reporting

There have been no changes in our internal control over financial reporting during the fourth quarter ended December 31, 2015 that have materially affected or are reasonably likely to materially affect our internal control over financial reporting.

Item 9B. Other Information.

None.

PART III

Item 10. Directors, Executive Officers and Corporate Governance.

Directors

The information with respect to our directors set forth under the caption "Election of Directors" in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 19, 2016 is incorporated herein by reference.

Audit Committee

The information with respect to our Audit Committee and our audit committee financial experts serving on the Audit Committee is set forth under the caption "Corporate Governance – Committees of the Board of Directors – Audit Committee" in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 19, 2016 is incorporated herein by reference.

Executive Officers

The information with respect to our executive officers set forth under the caption "Management – Executive Officers" in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 19, 2016 is incorporated herein by reference.

Section 16(a) Compliance

The information with respect to compliance with Section 16(a) of the Exchange Act set forth under the caption "Section 16(a) Beneficial Ownership Reporting Compliance" in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 19, 2016 is incorporated herein by reference.

Stockholder Nominees

The information with respect to the procedures by which stockholders may recommend nominees to the Board of Directors set forth under the caption "Corporate Governance – Nomination of Directors – Nominations by Our Stockholders" in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 19, 2016 is incorporated herein by reference.

Corporate Governance Documents

We have adopted a Code of Conduct that applies to all of our directors, officers and employees and a Code of Ethics for Senior Financial Officers. These documents, as well as the charters of the Audit Committee and the Compensation Committee, are available on our website at www.acadiahealthcare.com on the Investors webpage under the caption "Corporate Governance." Upon the written request of any person, we will furnish, without charge, a copy of any of these documents. Requests should be directed to Acadia Healthcare Company, Inc., 6100 Tower Circle, Suite 1000, Franklin, Tennessee 37067, Attention: Christopher L. Howard, Esq. We intend to disclose any amendments to our Code of Ethics and any waiver from a provision of our code, as required by the SEC, on our website.

Item 11. Executive Compensation

The information with respect to the compensation of our executive officers set forth under the captions "Executive Compensation," "Compensation Discussion and Analysis," "Director Compensation" and "Compensation Committee Report" in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 19, 2016 is incorporated herein by reference.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

The information with respect to security ownership of certain beneficial owners and management and related stockholder matters set forth under the caption "Security Ownership of Certain Beneficial Owners and Management" in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 19, 2016 is incorporated herein by reference.

The information with respect to securities authorized for issuance under equity compensation plans set forth under the caption "Securities Authorized for Issuance Under Equity Compensation Plans" in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 19, 2016 is incorporated herein by reference.

Item 13. Certain Relationships and Related Transactions, and Director Independence

The information with respect to certain relationships and related transactions and director independence set forth under the captions "Certain Relationships and Related Transactions" and "Corporate Governance – Independence of the Board of Directors" in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 19, 2016 is incorporated herein by reference.

Item 14. Principal Accounting Fees and Services

The information with respect to the fees paid to and services provided by our principal accountants set forth under the caption "Ratification of Appointment of Independent Registered Public Accounting Firm" in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 19, 2016 is incorporated herein by reference.

PART IV

Item 15. Exhibits and Financial Statement Schedules.

(a) The following documents are filed as part of this Annual Report on Form 10-K:

1. *Consolidated Financial Statements*:

The consolidated financial statements required to be included in Part II, Item 8, Financial Statements and Supplementary Data, begin on Page F-1 and are submitted as a separate section of this report.

2. *Financial Statement Schedules*:

All schedules are omitted because they are not applicable or are not required, or because the required information is included in the consolidated financial statements or notes in this report.

3. *Exhibits*:

Exhibit No.	Exhibit Description
2.1	Agreement and Plan of Merger, dated May 23, 2011, by and among Acadia Healthcare Company, Inc. (the "Company"), Acadia Merger Sub, LLC and PHC, Inc. (a)
2.2	Agreement and Plan of Merger, dated February 17, 2011, by and among the Company (f/k/a Acadia Healthcare Company, LLC), Acadia—YFCS Acquisition Company, Inc., Acadia—YFCS Holdings, Inc., Youth & Family Centered Services, Inc., each of the stockholders who are signatories thereto, and TA Associates, Inc., solely in the capacity as Stockholders' Representative. (b)
2.3	Asset Purchase Agreement, dated as of March 15, 2011, between Universal Health Services, Inc. and PHC, Inc. for the acquisition of MeadowWood Behavioral Health System. (c)
2.4	Membership Interest Purchase Agreement, dated December 30, 2011, by and among Hermitage Behavioral, LLC, Haven Behavioral Healthcare Holdings, LLC and Haven Behavioral Healthcare, Inc. (d)
2.5	Asset Purchase Agreement, dated August 28, 2012, by and between Timberline Knolls, LLC, and TK Behavioral, LLC. (e)
2.6	Acquisition Agreement, dated November 21, 2012, by and among (i) Behavioral Centers of America, LLC, (ii) Behavioral Centers of America Holdings, LLC, (iii) Linden BCA Blocker Corp., (iv) SBOF-BCA Holdings Corporation, (v) HEP BCA Holdings Corp. (vi) Siguler Guff Small Buyout Opportunities Fund, LP, and Siguler Guff Small Buyout Opportunities Fund (F), LP, (vii) Health Enterprise Partners, L.P., HEP BCA Co-Investors, LLC, (viii) Linden Capital Partners A, LP, (ix) Commodore Acquisition Sub, LLC, and (x) the Company (the "BCA Purchase Agreement"). (f)
2.7	Amendment No. 1, dated as of December 31, 2012, to the BCA Purchase Agreement. (g)
2.8	Membership Interest Purchase Agreement, dated November 23, 2012 by and among 2C4K, L.P., ARTC Acquisitions, Inc., Acadia Vista, LLC and the Company. (f)
2.9	Amendment, dated as of December 31, 2012, to Membership Interest Purchase Agreement by and among 2C4K, LP, ARTC Acquisitions, Inc., Acadia Vista, LLC and the Company. (g)
2.10	Stock Purchase Agreement, dated as of March 29, 2013, by and among First Ten Broeck Tampa, Inc., UMC Ten Broeck, Inc., Capestrano Holding 12, Inc., Donald R. Dizney, David A. Dizney and Acadia Merger Sub, LLC. (h)
2.11	Agreement, dated June 3, 2014, by and among Partnerships in Care Holdings Limited, The Royal Bank of Scotland plc, Piper Holdco 2, Ltd. and the Company. (i)
2.12	Agreement and Plan of Merger, dated as of October 29, 2014, by and among the Company, Copper Acquisition Co., Inc. and CRC Health Group, Inc. (j)

Exhibit No.	Exhibit Description
2.13	Sale and Purchase Deed, dated as of December 31, 2015, by and among Whitewell UK Investments 1 Limited, the institutional sellers named therein, Appleby Trust (Jersey) Limited, the management sellers named therein, and the Company. (ii)
2.14	Amendment to Sale the Purchase Deed by and among Whitewell UK Investments 1 Limited, the representative of the institutional sellers named therein, the representative of the management sellers named therein, and the Company. (jj)
3.1	Amended and Restated Certificate of Incorporation, as filed on October 28, 2011 with the Secretary of State of the State of Delaware. (k)
3.2	Amended and Restated Bylaws of the Company. (k)
4.1	Indenture, dated as of March 12, 2013, among the Company, the guarantors named therein and U.S. Bank National Association, as Trustee. (m)
4.2	Form of 6.125% Senior Note due 2021. (Included in Exhibit 4.1)
4.3	Registration Rights Agreement, dated March 12, 2013, among the Company, the guarantors named therein and Merrill Lynch, Pierce, Fenner & Smith Incorporated. (m)
4.4	Indenture, dated July 1, 2014, by and among the Company, the guarantors party thereto and U.S. Bank National Association, as Trustee. (n)
4.5	Supplemental Indenture, dated as of August 4, 2014, to the Indenture, dated as of July 1, 2014, among the Company, the guarantors named therein and U.S. Bank National Association, as Trustee. (o)
4.6	Form of 5.125% Senior Note due 2022 (Included in Exhibit 4.4).
4.7	Registration Rights Agreement, dated July 1, 2014, by and among the Company, the guarantors party thereto and Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC, as Representatives of the Initial Purchasers. (n)
4.8	Indenture, dated February 11, 2015, by and among the Company, the guarantors party thereto and U.S. Bank National Association, as Trustee. (p)
4.9	Form of 5.625% Senior Note due 2023 (Included in Exhibit 4.8).
4.10	Registration Rights Agreement, dated February 11, 2015, by and among the Company, the guarantors party thereto and Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC, as Representatives of the Initial Purchasers. (p)
4.11	Registration Rights Agreement, dated September 21, 2015, by and among the Company, the guarantors party thereto and Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC, as Representatives of the Initial Purchasers. (hh)
4.12	Indenture, dated February 16, 2016, by and among the Company, the guarantors party thereto and Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC, as Representatives of the Initial Purchasers. (mm)
4.13	Form of 6.500% Senior Note due 2024 (Included in Exhibit 4.12).
4.14	Registration Rights Agreement, dated February 16, 2016, by and among the Company, the guarantors party thereto and Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC, as Representatives of the Initial Purchasers. (mm)
4.15	Amended and Restated Stockholders Agreement, dated as of October 29, 2014, by and among the Company and each of the stockholders named therein. (j)

Exhibit No.	Exhibit Description
4.16	Specimen Acadia Healthcare Company, Inc. Common Stock Certificate to be issued to holders of Acadia Healthcare Company, Inc. Common Stock. (r)
4.17	Second Amended and Restated Registration Rights Agreement, dated as of October 29, 2014, by and among the Company and each of the parties named therein. (j)
4.18	Amendment, dated February 11, 2015, to the Second Amended and Restated Registration Rights Agreement dated as of October 29, 2014, by and among the Company and each of the parties named therein. (p)
4.19	Third Amended and Restated Registration Rights Agreement, dated as of December 31, 2015, by and among the Company and each of the parties named therein. (ii)
4.20	Form of Subscription Agreement and Warrant. (s)
10.1	Amended and Restated Credit Agreement, dated December 31, 2012, by and among Bank of America, NA (Administrative Agent, Swing Line Lender and L/C Issuer) and the Company (f/k/a Acadia Healthcare Company, LLC), the guarantors listed on the signature pages thereto, and the lenders listed on the signature pages thereto (the "Credit Agreement"). (g)
10.2	First Amendment, dated March 11, 2013, to the Credit Agreement. (m)
10.3	Second Amendment, dated June 28, 2013, to the Credit Agreement. (t)
10.4	Third Amendment, dated September 30, 2013, to the Credit Agreement. (u)
10.5	Fourth Amendment, dated February 13, 2014, to the Credit Agreement. (v)
10.6	Fifth Amendment, dated June 16, 2014, to the Credit Agreement. (w)
10.7	Sixth Amendment, dated December 15, 2014, to the Credit Agreement. (x)
10.8	Seventh Amendment, dated February 6, 2015, to the Credit Agreement. (p)
10.9	First Incremental Facility Amendment, dated February 11, 2015, to the Credit Agreement. (p)
10.10	Eighth Amendment, dated April 22, 2015, to the Credit Agreement. (ff)
10.11	Ninth Amendment, dated January 25, 2016, to the Credit Agreement. (kk)
10.12	Second Incremental Facility Amendment, dated February 16, 2016, to the Credit Agreement. (mm)
†10.13	Amended and Restated Employment Agreement, dated April 7, 2014, among the Company, Acadia Management Company, Inc. and Joey A. Jacobs. (y)
†10.14	Amended and Restated Employment Agreement, dated April 7, 2014, among the Company, Acadia Management Company, Inc. and Brent Turner. (y)
†10.15	Amended and Restated Employment Agreement, dated April 7, 2014, among the Company, Acadia Management Company, Inc. and Ronald M. Fincher. (y)
†10.16	Amended and Restated Employment Agreement, dated April 7, 2014, among the Company, Acadia Management Company, Inc. and Christopher L. Howard. (y)
†10.17	Employment Agreement, dated April 7, 2014, by and among the Company, Acadia Management Company, Inc. and David M. Duckworth. (y)

Exhibit No.	Exhibit Description
†10.18	Employment Agreement, dated as of May 23, 2011, by and between the Company and Bruce A. Shear. (b)
†10.19	PHC, Inc.'s 1993 Stock Purchase and Option Plan, as amended December 2002. (z)
†10.20	PHC, Inc.'s 1995 Non-Employee Director Stock Option Plan, as amended December 2002. (z)
†10.21	PHC, Inc.'s 1995 Employee Stock Purchase Plan, as amended December 2002. (z)
†10.22	PHC, Inc.'s 2004 Non-Employee Director Stock Option Plan. (aa)
†10.23	PHC, Inc.'s 2005 Employee Stock Purchase Plan. (bb)
†10.24	PHC, Inc.'s 2003 Stock Purchase and Option Plan, as amended December 2007. (bb)
†10.25	Acadia Healthcare Company, Inc. Incentive Compensation Plan, effective May 23, 2013. (cc)
†10.26	Form of Restricted Stock Unit Agreement. (b)
†10.27	Form of Incentive Stock Option Agreement. (b)
†10.28	Form of Non-Qualified Stock Option Agreement. (b)
†10.29	Form of Restricted Stock Agreement. (b)
†10.30	Form of Stock Appreciation Rights Agreement. (b)
†10.31	Acadia Healthcare Company, Inc. Nonqualified Deferred Compensation Plan, effective February 1, 2013. (dd)
†10.32	Nonmanagement Director Compensation Program, effective January 1, 2013. (dd)
10.33	Form of Indemnification Agreement (for directors and officers affiliated with Waud Capital Partners or Bain Capital). (k)
10.34	Form of Indemnification Agreement (for directors and officers not affiliated with Waud Capital Partners or Bain Capital). (k)
10.35	Purchase Agreement, dated March 7, 2013, by and among the Company, the guarantors and Merrill Lynch, Pierce, Fenner & Smith Incorporated as representative of the initial purchasers named therein. (m)
10.36	Purchase Agreement, dated June 17, 2014, by and among the Company, the guarantors, Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC as representatives of the initial purchasers named therein. (l)
10.37	Purchase Agreement, dated February 5, 2015, by and among the Company, the guarantors, Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC as representatives of the initial purchasers named therein. (ee)
10.38	Purchase Agreement, dated September 14, 2015, by and among the Company, the guarantors, Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC, as representatives of the initial purchasers named therein. (gg)
10.39	Purchase Agreement, dated February 4, 2016, by and among the Company, the guarantors, Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC as representatives of the initial purchasers named therein. (ll)
21*	Subsidiaries of the Company.
23*	Consent of Independent Registered Public Accounting Firm.
31.1*	Rule 13a-14(a) Certification of the Chief Executive Officer of the Company pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.

Exhibit No.	Exhibit Description
31.2*	Rule 13a-14(a) Certification of the Chief Financial Officer of the Company pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1*	Section 1350 Certification of Chairman of the Board and Chief Executive Officer of the Company pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2*	Section 1350 Certification of Chief Financial Officer of the Company pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS**	XBRL Instance Document.
101.SCH**	XBRL Taxonomy Extension Schema Document.
101.CAL**	XBRL Taxonomy Calculation Linkbase Document.
101.LAB**	XBRL Taxonomy Labels Linkbase Document.
101.PRE**	XBRL Taxonomy Presentation Linkbase Document.

† Indicates management contract or compensatory plan or arrangement.
* Filed herewith.
** The XBRL related information in Exhibit 101 to this Annual Report on Form 10-K shall not be deemed "filed" for purposes of Section 18 of the Securities Exchange Act of 1934, as amended, or otherwise subject to liability of that section and shall not be incorporated by reference into any filing or other document pursuant to the Securities Act of 1933, as amended, except as shall be expressly set forth by specific reference in such filing or document.
(a) Incorporated by reference to exhibits filed with PHC, Inc.'s Current Report on Form 8-K filed May 25, 2011 (File No. 001-33323).
(b) Incorporated by reference to exhibits filed with the Company's registration statement on Form S-4, as amended (File No. 333-175523), originally filed with the SEC on July 13, 2011.
(c) Incorporated by reference to exhibits filed with PHC, Inc.'s Current Report on Form 8-K filed March 18, 2011 (File No. 001-33323).
(d) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed January 5, 2012 (File No. 001-35331).
(e) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed September 4, 2012 (File No. 001-35331).
(f) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed November 27, 2012 (File No. 001-35331).
(g) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed January 2, 2013 (File No. 001-35331).
(h) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed April 4, 2013 (File No. 001-35331).
(i) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed June 6, 2014 (File No. 001-35331).
(j) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed October 30, 2014 (File No. 001-35331).
(k) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed November 1, 2011 (File No. 001-35331).
(l) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed June 18, 2014 (File No. 001-35331).
(m) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed March 12, 2013 (File No. 001-35331).
(n) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed July 2, 2014 (File No. 001-35331).

(o) Incorporated by reference to exhibits filed with the Company's registration statement on Form S-4 filed August 8, 2014 (File No. 333-198004).
(p) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed February 12, 2015 (File No. 001-35331).
(q) Incorporated by reference to exhibits filed with the Company's Quarterly Report on Form 10-Q for the three months ended June 30, 2012 (File No. 001-35331).
(r) Incorporated by reference to exhibits filed with the Company's registration statement on Form S-1, as amended (File No. 333-175523), originally filed with the SEC on November 23, 2011.
(s) Incorporated by reference to exhibits filed with PHC, Inc.'s Current Report on Form 8-K filed May 13, 2004 (File No. 001-33323).
(t) Incorporated by reference to exhibits filed with the Company's Quarterly Report on Form 10-Q for the three months ended June 30, 2013 (File No. 001-35331).
(u) Incorporated by reference to exhibits filed with the Company's Quarterly Report on Form 10-Q for the three months ended September 30, 2013 (File No. 001-35331).
(v) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed February 19, 2014 (File No. 001-35331).
(w) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed June 17, 2014 (File No. 001-35331).
(x) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed December 15, 2014 (File No. 001-35331).
(y) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed April 11, 2014 (File No. 001-35331).
(z) Incorporated by reference to exhibits filed with PHC, Inc.'s registration statement on Form S-8 filed January 8, 2003 (File No. 333-102402).
(aa) Incorporated by reference to exhibits filed with PHC, Inc.'s registration statement on Form S-8 filed April 5, 2005 (File No. 333-123842).
(bb) Incorporated by reference to exhibits filed with PHC, Inc.'s registration statement on Form S-8 filed March 6, 2008 (File No. 333-149579).
(cc) Incorporated by reference to exhibits filed with the Company's registration statement on Form S-8 filed July 30, 2013 (File No. 333-190232).
(dd) Incorporated by reference to exhibits filed with the Company's Quarterly Report on Form 10-Q for the three months ended March 31, 2013 (File No. 001-35331).
(ee) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed February 6, 2015 (File No. 001-35331).
(ff) Incorporated by reference to exhibits filed with the Company's Quarterly Report on Form 10-Q for the three months ended March 31, 2015 (File No. 001-35331).
(gg) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed September 15, 2015 (File No. 001-35331).
(hh) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed September 21, 2015 (File No. 001-35331).
(ii) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed January 4, 2016 (File No. 001-35331).
(jj) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed January 8, 2016 (File No. 001-35331).
(kk) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed January 27, 2016 (File No. 001-35331).
(ll) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed February 5, 2016 (File No. 001-35331).
(mm) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed February 16, 2016 (File No. 001-35331).

INDEX TO CONSOLIDATED FINANCIAL STATEMENTS

MANAGEMENT'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING

Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Exchange Act Rules 13a-15(f) and 15d-15(f). Under the supervision and with the participation of our management, including our Chief Executive Officer and Chief Financial Officer, we conducted an evaluation of the effectiveness of our internal control over financial reporting as of December 31, 2015 based on the framework in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (COSO). Based on that evaluation, our management concluded that our internal control over financial reporting was effective as of December 31, 2015.

We acquired CRC Health effective February 11, 2015, QAM effective March 1, 2015, two facilities from Choice Lifestyles effective April 1, 2015, Pastoral Care Group effective April 1, 2015, Mildmay Oaks effective April 1, 2015, 15 facilities from Care UK Limited effective June 1, 2015, one facility from Choice Lifestyles effective June 1, 2015, The Manor Clinic effective July 1, 2015, Belmont effective July 1, 2015, Southcoast effective August 31, 2015, three facilities from The Danshell Group effective September 1, 2015, two facilities from Health and Social Care Partnerships effective September 1, 2015, Manor Hall effective September 1, 2015, Meadow View effective October 1, 2015, Cleveland House effective November 1, 2015, Duffy's effective November 1, 2015, Discovery House effective November 1, 2015 and MMO effective December 1, 2015. We excluded these facilities from our assessment of and conclusion on the effectiveness of our internal control over financial reporting. For the year ended December 31, 2015, these facilities contributed $553.8 million and $66.2 million of our total revenues and net income, respectively, and as of December 31, 2015, accounted for $1.4 billion and $187.8 million of our total and net assets, respectively.

Our accompanying consolidated financial statements have been audited by the independent registered public accounting firm of Ernst & Young LLP. Reports of the independent registered public accounting firm, including the independent registered public accounting firm's report on our internal control over financial reporting, are included in this report.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
Acadia Healthcare Company, Inc.

We have audited Acadia Healthcare Company, Inc.'s internal control over financial reporting as of December 31, 2015, based on criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the "COSO criteria"). Acadia Healthcare Company, Inc.'s management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

As indicated in the accompanying Management's Report on Internal Control Over Financial Reporting, management's assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of CRC Health, QAM, Choice Lifestyles, Care UK Limited, Pastoral Care Group, Mildmay Oaks, The Manor Clinic, The Danshell Group, Health and Social Care Partnerships, Manor Hall, Belmont, Southcoast, Duffy's, Discovery House, Meadow View, Cleveland House, and MMO, which are included in the December 31, 2015 consolidated financial statements of Acadia Healthcare Company, Inc. and constituted $1.4 billion and $187.8 million of total and net assets, respectively, as of December 31, 2015 and $553.8 million and $66.2 million of revenues and net income, respectively, for the year then ended. Our audit of internal control over financial reporting of Acadia Healthcare Company, Inc. also did not include an evaluation of the internal control over financial reporting of CRC Health, QAM, Care UK Limited, Choice Lifestyles, Pastoral Care Group, Mildmay Oaks, The Manor Clinic, The Danshell Group, Health and Social Care Partnerships, Manor Hall, Belmont, Southcoast, Duffy's, Discovery House, Meadowview, Cleveland House, and MMO.

In our opinion, Acadia Healthcare Company, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2015, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Acadia Healthcare Company, Inc. as of December 31, 2015 and 2014, and the related consolidated statements of income, comprehensive income, equity, and cash flows for each of the three years in the period ended December 31, 2015 and our report dated February 25, 2016 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Nashville, Tennessee
February 25, 2016

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
Acadia Healthcare Company, Inc.

We have audited the accompanying consolidated balance sheets of Acadia Healthcare Company, Inc. as of December 31, 2015 and 2014, and the related consolidated statements of income, comprehensive income, equity, and cash flows for each of the three years in the period ended December 31, 2015. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Acadia Healthcare Company, Inc. at December 31, 2015 and 2014, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2015, in conformity with U.S. generally accepted accounting principles.

As discussed in Note 2 to the consolidated financial statements, the Company changed its presentation of debt issuance costs on its consolidated balance sheets, as a result of the adoption of the amendments to the FASB Accounting Standards Codification resulting from Accounting Standards Update No. 2015-03, Simplifying the Presentation of Debt Issuance Costs, and the Company changed the classification of all deferred tax assets and liabilities to noncurrent on the December 31, 2015 consolidated balance sheet as a result of the adoption of the amendments to the FASB Accounting Standards Codification resulting from Accounting Standards Update No. 2015-17, Balance Sheet Classification of Deferred Taxes.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Acadia Healthcare Company, Inc.'s internal control over financial reporting as of December 31, 2015, based on criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework), and our report dated February 25, 2016 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Nashville, Tennessee
February 25, 2016

SUPPLEMENTAL #1
March 28, 2016
11:49 am

Table of Contents

Acadia Healthcare Company, Inc.
Consolidated Balance Sheets

	December 31, 2015	December 31, 2014
	(In thousands, except share and per share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 11,215	$ 94,040
Accounts receivable, net of allowance for doubtful accounts of $29,332 and $22,449, respectively	216,626	118,378
Deferred tax assets	—	20,155
Other current assets	66,895	41,570
Total current assets	294,736	274,143
Property and equipment:		
Land	214,138	132,406
Building and improvements	1,277,800	858,055
Equipment	141,543	73,584
Construction in progress	195,042	66,268
Less accumulated depreciation	(119,470)	(60,613)
Property and equipment, net	1,709,053	1,069,700
Goodwill	2,128,215	802,986
Intangible assets, net	59,575	21,636
Deferred tax assets – noncurrent	49,114	13,141
Other assets	38,515	25,349
Total assets	$ 4,279,208	$ 2,206,955
LIABILITIES AND EQUITY		
Current liabilities:		
Current portion of long-term debt	$ 45,360	$ 26,965
Accounts payable	91,341	48,696
Accrued salaries and benefits	80,696	59,317
Other accrued liabilities	72,806	30,956
Total current liabilities	290,203	165,934
Long-term debt	2,195,384	1,052,670
Deferred tax liabilities – noncurrent	23,936	63,880
Other liabilities	78,602	43,506
Total liabilities	2,588,125	1,325,990
Redeemable noncontrolling interests	8,055	—
Equity:		
Preferred stock, $0.01 par value; 10,000,000 shares authorized, no shares issued	—	—
Common stock, $0.01 par value; 90,000,000 shares authorized; 70,745,746 and 59,211,859 issued and outstanding as of December 31, 2015 and 2014, respectively	707	592
Additional paid-in capital	1,572,972	847,301
Accumulated other comprehensive loss	(104,647)	(68,370)
Retained earnings	213,996	101,442
Total equity	1,683,028	880,965
Total liabilities and equity	$ 4,279,208	$ 2,206,955

See accompanying notes.

Table of Contents

Acadia Healthcare Company, Inc.
Consolidated Statements of Income

	Year Ended December 31,		
	2015	2014	2013
	(In thousands, except per share amounts)		
Revenue before provision for doubtful accounts	$1,829,619	$1,030,784	$ 735,109
Provision for doubtful accounts	(35,127)	(26,183)	(21,701)
Revenue	1,794,492	1,004,601	713,408
Salaries, wages and benefits (including equity-based compensation expense of $20,472, $10,058 and $5,249, respectively)	973,732	575,412	407,962
Professional fees	116,463	52,482	37,171
Supplies	80,663	48,422	37,569
Rents and leases	32,528	12,201	10,049
Other operating expenses	206,746	110,654	80,572
Depreciation and amortization	63,550	32,667	17,090
Interest expense, net	106,742	48,221	37,250
Debt extinguishment costs	10,818	—	9,350
Loss (gain) on foreign currency derivatives	1,926	(15,262)	—
Transaction-related expenses	36,571	13,650	7,150
Total expenses	1,629,739	878,447	644,163
Income from continuing operations before income taxes	164,753	126,154	69,245
Provision for income taxes	53,388	42,922	25,975
Income from continuing operations	111,365	83,232	43,270
Income (loss) from discontinued operations, net of income taxes	111	(192)	(691)
Net income	111,476	83,040	42,579
Net loss attributable to noncontrolling interests	1,078	—	—
Net income attributable to Acadia Healthcare Company, Inc.	$ 112,554	$ 83,040	$ 42,579
Basic earnings attributable to Acadia Healthcare Company, Inc. stockholders:			
Income from continuing operations	$ 1.65	$ 1.51	$ 0.87
Loss from discontinued operations	—	—	(0.02)
Net income	$ 1.65	$ 1.51	$ 0.85
Diluted earnings attributable to Acadia Healthcare Company, Inc. stockholders:			
Income from continuing operations	$ 1.64	$ 1.50	$ 0.86
Loss from discontinued operations	—	—	(0.01)
Net income	$ 1.64	$ 1.50	$ 0.85
Weighted-average shares outstanding:			
Basic	68,085	55,063	50,004
Diluted	68,391	55,327	50,261

See accompanying notes.

SUPPLEMENTAL #1

March 28, 2016

11:49 am

Acadia Healthcare Company, Inc.
Consolidated Statements of Comprehensive Income

	Year Ended December 31,		
	2015	2014	2013
	(In thousands)		
Net income	$111,476	$ 83,040	$42,579
Other comprehensive loss:			
Foreign currency translation loss	(40,103)	(66,206)	—
Pension liability adjustment, net of tax of $0.9 million, $0.6 and $0, respectively	3,826	(2,164)	—
Other comprehensive loss	(36,277)	(68,370)	—
Comprehensive loss	75,199	14,670	42,579
Comprehensive loss attributable to noncontrolling interests	1,078	—	—
Comprehensive (loss) income attributable to Acadia Healthcare Company. Inc.	$ 76,277	$ 14,670	$42,579

See accompanying notes.

Acadia Healthcare Company, Inc.
Consolidated Statements of Equity

	Common Stock		Additional Paid-in Capital	Other Comprehensive Loss	Retained Earnings (Accumulated Deficit)	Total
	Shares	Amount				
Balance at January 1, 2013	49,887	$ 499	$ 456,228	$ —	$ (24,177)	$ 432,550
Common stock issued under stock incentive plans	184	2	311	—	—	313
Common stock withheld for minimum statutory taxes	—	—	(1,555)	—	—	(1,555)
Equity-based compensation expense	—	—	5,249	—	—	5,249
Excess tax benefit from equity awards	—	—	1,779	—	—	1,779
Issuance of common stock, net	—	—	(205)	—	—	(205)
Net income	—	—	—	—	42,579	42,579
Balance at December 31, 2013	50,071	$ 501	$ 461,807	$ —	$ 18,402	$ 480,710
Common stock issued under stock incentive plans	259	2	568	—	—	570
Common stock withheld for minimum statutory taxes	—	—	(4,669)	—	—	(4,669)
Equity-based compensation expense	—	—	10,058	—	—	10,058
Excess tax benefit from equity awards	—	—	4,617	—	—	4,617
Issuance of common stock, net	8,882	89	374,342	—	—	374,431
Other	—	—	578	—	—	578
Other comprehensive loss	—	—	—	(68,370)	—	(68,370)
Net income	—	—	—	—	83,040	83,040
Balance at December 31, 2014	59,212	$ 592	$ 847,301	$ (68,370)	$ 101,442	$ 880,965
Common stock issued under stock incentive plans	384	4	1,811	—	—	1,815
Common stock withheld for minimum statutory taxes	—	—	(9,577)	—	—	(9,577)
Equity-based compensation expense	—	—	20,472	—	—	20,472
Excess tax benefit from equity awards	—	—	309	—	—	309
Issuance of common stock, net	11,150	111	711,406	—	—	711,517
Other comprehensive loss	—	—	—	(36,277)	—	(36,277)
Other	—	—	1,250	—	—	1,250
Net income attributable to Acadia Healthcare Company, Inc. stockholders	—	—	—	—	112,554	112,554
Balance at December 31, 2015	70,746	$ 707	$1,572,972	$ (104,647)	$ 213,996	$1,683,028

See accompanying notes.

Table of Contents

Acadia Healthcare Company, Inc.
Consolidated Statements of Cash Flows

	Year Ended December 31,		
	2015	2014	2013
	(In thousands)		
Operating activities:			
Net income	$ 111,476	$ 83,040	$ 42,579
Adjustments to reconcile net income to net cash provided by continuing operating activities:			
Depreciation and amortization	63,550	32,667	17,090
Amortization of debt issuance costs	6,709	3,198	2,264
Equity-based compensation expense	20,472	10,058	5,249
Deferred income tax expense	43,613	7,215	10,083
(Income) loss from discontinued operations, net of taxes	(111)	192	691
Debt extinguishment costs	10,818	—	9,350
Loss (gain) on foreign currency derivatives	1,926	(15,262)	—
Other	1,615	488	21
Change in operating assets and liabilities, net of effect of acquisitions:			
Accounts receivable, net	(24,954)	(15,110)	(21,242)
Other current assets	(2,717)	(2,011)	(3,652)
Other assets	(8,021)	(6,513)	(2,239)
Accounts payable and other accrued liabilities	6,868	2,793	(848)
Accrued salaries and benefits	1,658	11,980	2,803
Other liabilities	9,236	2,749	3,181
Net cash provided by continuing operating activities	242,138	115,484	65,330
Net cash (used in) provided by discontinued operating activities	(1,735)	(198)	232
Net cash provided by operating activities	240,403	115,286	65,562
Investing activities:			
Cash paid for acquisitions, net of cash acquired	(574,777)	(738,702)	(164,019)
Cash paid for capital expenditures	(276,047)	(113,244)	(68,941)
Cash paid for real estate acquisitions	(26,622)	(23,177)	(8,092)
Settlement of foreign currency derivatives	(1,926)	15,262	—
Other	(5,099)	(913)	(1,926)
Net cash used in investing activities	(884,471)	(860,774)	(242,978)
Financing activities:			
Borrowings on long-term debt	1,150,000	542,500	150,000
Borrowings on revolving credit facility	468,000	230,500	61,500
Principal payments on revolving credit facility	(310,000)	(284,000)	(8,000)
Principal payments on long-term debt	(31,965)	(7,695)	(7,680)
Repayment of assumed CRC debt	(904,467)	—	—
Repayment of senior notes	(97,500)	—	(52,500)
Payment of debt issuance costs	(26,421)	(12,993)	(4,307)
Payment of premium on senior notes	(7,480)	—	(6,759)
Issuances of common stock, net	331,308	374,431	(205)
Common stock withheld for minimum statutory taxes, net	(7,762)	(4,099)	(1,242)
Excess tax benefit from equity awards	309	4,617	1,779
Cash paid for contingent consideration	—	(5,000)	—
Other	(420)	(289)	—
Net cash provided by financing activities	563,602	837,972	132,586
Effect of exchange rate changes on cash	(2,359)	(3,013)	—
Net increase(decrease) in cash and cash equivalents	(82,825)	89,471	(44,830)
Cash and cash equivalents at beginning of the period	94,040	4,569	49,399
Cash and cash equivalents at end of the period	$ 11,215	$ 94,040	$ 4,569

(continued on next page)

Table of Contents

Acadia Healthcare Company, Inc.
Consolidated Statements of Cash Flows (continued)

	Year Ended December 31,		
	2015	2014	2013
	(In thousands)		
Supplemental Cash Flow Information:			
Cash paid for interest	$ 87,034	$ 36,776	$ 33,270
Cash paid for income taxes	$ 6,911	$ 32,257	$ 16,960
Significant Non-Cash Transactions:			
Contingent consideration issued in connection with acquisition	$ —	$ 1,467	$ —
Effect of acquisitions:			
Assets acquired, excluding cash	$ 1,988,634	$819,518	$192,928
Liabilities assumed	(1,024,515)	(78,849)	(17,725)
Issuance of common stock in connection with acquisition	(380,210)	—	—
Redeemable noncontrolling interest resulting from acquisitions	(9,132)	—	—
Deposits paid for acquisitions	—	—	500
Prior year deposits paid for acquisitions	—	(500)	(11,684)
Contingent consideration issued in connection with acquisition	—	(1,467)	—
Cash paid for acquisitions, net of cash acquired	$ 574,777	$738,702	$164,019

See accompanying notes.

Acadia Healthcare Company, Inc.
Notes to Consolidated Financial Statements
December 31, 2015

1. Description of Business and Basis of Presentation

Description of Business

Acadia Healthcare Company, Inc. (the "Company") develops and operates inpatient psychiatric facilities, residential treatment centers, group homes, substance abuse facilities and facilities providing outpatient behavioral healthcare services to serve the behavioral health and recovery needs of communities throughout the United States, the United Kingdom and Puerto Rico. At December 31, 2015, the Company operated 258 behavioral healthcare facilities with over 9,900 beds in 39 states, the United Kingdom and Puerto Rico.

Basis of Presentation

The business of the Company is conducted through limited liability companies, partnerships and C-corporations. The Company's consolidated financial statements include the accounts of the Company and all subsidiaries controlled by the Company through its' direct or indirect ownership of majority interests and exclusive rights granted to the Company as the controlling member of an entity. All intercompany accounts and transactions have been eliminated in consolidation.

The accompanying consolidated financial statements have been prepared in accordance with U.S. generally accepted accounting principles ("GAAP"). The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates. The majority of the Company's expenses are "cost of revenue" items. Costs that could be classified as general and administrative expenses include the Company's corporate office costs, which were $68.3 million, $36.9 million and $29.0 million for the years ended December 31, 2015, 2014 and 2013, respectively.

Certain reclassifications have been made to prior years to conform to the current year presentation.

2. Summary of Significant Accounting Policies

Cash and Cash Equivalents

The Company considers all highly liquid investments with original maturities of three months or less to be cash equivalents. At times, cash and cash equivalent balances may exceed federally insured limits. Management believes that the Company mitigates any risks by depositing cash and investing in cash equivalents with major financial institutions.

Revenue and Accounts Receivable

Revenue is primarily derived from services rendered to patients for inpatient psychiatric and substance abuse care, outpatient psychiatric care and adolescent residential treatment. The Company receives payments from the following sources for services rendered in our facilities: (i) state governments under their respective Medicaid and other programs; (ii) commercial insurers; (iii) the federal government under the Medicare program administered by CMS; (iv) the NHS (including Local Authorities) in the United Kingdom; and (v) individual patients and clients. Revenue is recorded in the period in which services are provided at established billing rates less contractual adjustments based on amounts reimbursable by Medicare or Medicaid under provisions of cost or prospective reimbursement formulas or amounts due from other third-party payors at contractually determined rates.

The following table presents revenue by payor type as a percentage of revenue before provision for doubtful accounts:

	Year Ended December 31,		
	2015	2014	2013
Commercial	23.1%	23.0%	24.9%
Medicare	11.7	19.4	21.5
Medicaid	33.3	38.3	48.0
NHS	19.5	14.5	—
Self-Pay	9.6	2.5	3.4
Other	2.8	2.3	2.2
Revenue	100%	100%	100%

On a combined basis, revenue related to the Medicare and Medicaid programs were 45%, 58% and 70% of all revenue before provision for doubtful accounts for the years ended December 31, 2015, 2014 and 2013, respectively. The Company's concentration of credit risk from other payors is reduced by the large number of payors and their geographic dispersion. The Company generated approximately 20% of its revenue for the year ended December 31, 2015 from facilities located in the United Kingdom, approximately 15% and 12% of its revenue from facilities located in the United Kingdom and Arkansas, respectively, for the year ended December 31, 2014 and approximately 17% of its revenue from facilities located in Arkansas for the year ended December 31, 2013.

Allowance for Contractual Discounts

The Company derives a significant portion of its revenues from Medicare, Medicaid and other payors that receive discounts from established billing rates. The Medicare and Medicaid regulations and various managed care contracts under which these discounts must be calculated are complex, subject to interpretation and adjustment, and may include multiple reimbursement mechanisms for different types of services provided in the Company's inpatient facilities and cost settlement provisions. Management estimates the allowance for contractual discounts on a payor-specific basis given its interpretation of the applicable regulations or contract terms. The services authorized and provided and related reimbursement are often subject to interpretation that could result in payments that differ from the Company's estimates. Additionally, updated regulations and contract renegotiations occur frequently, necessitating regular review and assessment of the estimation process by management.

Settlements under cost reimbursement agreements with third-party payors are estimated and recorded in the period in which the related services are rendered and are adjusted in future periods as final settlements are determined. Final determination of amounts earned under the Medicare and Medicaid programs often occurs in subsequent years because of audits by such programs, rights of appeal and the application of numerous technical provisions. In the opinion of management, adequate provision has been made for any adjustments and final settlements. However, there can be no assurance that any such adjustments and final settlements will not have a material effect on the Company's financial condition or results of operations. The Company's cost report receivables were $4.2 million and $1.9 million at December 31, 2015 and 2014, respectively, and were included in other current assets in the consolidated balance sheets. Management believes that these receivables are properly stated and are not likely to be settled for a significantly different amount. The net adjustments to estimated cost report settlements resulted in increases to revenue of $1.9 million, $0.3 million and $0.2 million for the years ended December 31, 2015, 2014 and 2013, respectively.

Management believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of wrongdoing. While no such regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs.

Allowance for Doubtful Accounts

The Company's ability to collect outstanding patient receivables from third party payors is critical to its operating performance and cash flows. The primary collection risk with regard to patient receivables relates to uninsured patient accounts or patient accounts for which primary insurance has paid, but the portion owed by the patient remains outstanding. The Company estimates uncollectible accounts and establishes an allowance for doubtful accounts in order to adjust accounts receivable to estimated net realizable value. In evaluating the collectability of accounts receivable, the Company considers a number of factors, including the age of the accounts, historical collection experience, current economic conditions, and other relevant factors. Accounts receivable that are determined to be uncollectible based on the Company's policies are written off to the allowance for doubtful accounts. Significant changes in payor mix or business office operations could have a significant impact on the Company's results of operations and cash flows.

A summary of activity in the Company's allowance for doubtful accounts is as follows (in thousands):

	Balance at Beginning of Period	Additions Charged to Costs and Expenses	Accounts Written Off, Net of Recoveries	Balance at End of Period
Year ended December 31, 2013	$ 7,484	$ 21,701	$ (10,840)	$ 18,345
Year ended December 31, 2014	18,345	26,183	(22,079)	22,449
Year ended December 31, 2015	22,449	35,127	(28,244)	29,332

Charity Care

The Company provides care without charge to patients who are financially unable to pay for the healthcare services they receive based on Company policies and federal and state poverty thresholds. The costs of providing charity care services were $4.6 million, $2.5 million and $2.6 million for the years ended December 31, 2015, 2014 and 2013, respectively. The estimated cost of charity care services was determined using a ratio of cost to gross charges determined from our most recently filed Medicare cost reports and applying that ratio to the gross charges associated with providing charity care for the period.

Insurance

The Company is subject to medical malpractice and other lawsuits due to the nature of the services the Company provides. The Company's operations have professional and general liability insurance for claims in excess of a $1,000,000 self-insured retention with an insured excess limit of $50 million. The reserve for professional and general liability risks was estimated based on historical claims, demographic factors, industry trends, severity factors, and other actuarial assumptions. The estimated accrual for professional and general liabilities could be significantly affected should current and future occurrences differ from historical claim trends and expectations. While claims are monitored closely when estimating professional and general liability accruals, the complexity of the claims and wide range of potential outcomes often hampers timely adjustments to the assumptions used in these estimates. The professional and general liability reserve was $41.9 million as of December 31, 2015, of which $10.5 million was included in other accrued liabilities and $31.4 million was included in other long-term liabilities. The professional and general liability reserve was $16.3 million as of December 31, 2014, of which $4.2 million was included in other accrued liabilities and $12.1 million was included in other long-term liabilities. The Company estimates receivables for the portion of professional and general liability reserves that are recoverable under the Company's insurance policies. Such receivable was $21.3 million as of December 31, 2015, of which $5.3 million was included in other current assets and $16.0 million was included in other assets, and such receivable was $12.0 million as of December 31, 2014, of which $3.5 million was included in other current assets and $8.5 million was included in other assets.

The Company's statutory workers' compensation program is fully insured with a $500,000 deductible per accident. The workers' compensation liability was $14.7 million as of December 31, 2015, of which $7.5 million was included in accrued salaries and benefits and $7.2 million was included in other long-term liabilities, and such liability was $8.4 million as of December 31, 2014, of which $4.8 million was included in accrued salaries and benefits and $3.6 million was included in other long-term liabilities. The reserve for workers compensation claims was based upon independent actuarial estimates of future amounts that will be paid to claimants. Management believes that adequate provisions have been made for workers' compensation and professional and general liability risk exposures.

Property and Equipment and Other Long-Lived Assets

Property and equipment are recorded at cost. Depreciation is calculated on the straight-line basis over the estimated useful lives of the assets, which typically range from 10 to 50 years for buildings and improvements, three to seven years for equipment and the shorter of the lease term or estimated useful lives for leasehold improvements. When assets are sold or retired, the corresponding cost and accumulated depreciation are removed from the related accounts and any gain or loss is recorded in the period of sale or retirement. Repair and maintenance costs are expensed as incurred. Depreciation expense was $63.0 million, $32.1 million and $16.3 million for the years ended December 31, 2015, 2014 and 2013, respectively.

The carrying values of long-lived assets are reviewed for possible impairment whenever events, circumstances or operating results indicate that the carrying amount of an asset may not be recoverable. If this review indicates that the asset will not be recoverable, as determined based upon the undiscounted cash flows of the operating asset over the remaining useful lives, the carrying value of the asset will be reduced to its estimated fair value. Fair value estimates are based on independent appraisals, market values of comparable assets or internal evaluations of future net cash flows.

Goodwill and Indefinite-Lived Intangible Assets

The Company's goodwill and other indefinite-lived intangible assets, which consist of licenses and accreditations and certificates of need intangible assets that are not amortized, are evaluated for impairment annually during the fourth quarter or more frequently if events indicate that the carrying value of a reporting unit may not be recoverable. The Company has two operating segments, U.S. Facilities and U.K. Facilities, for segment reporting purposes, each of which represents a reporting unit for purposes of the Company's goodwill impairment test. Potential impairment is noted for a reporting unit if its carrying value exceeds the fair value of the reporting unit. For a reporting unit with potential impairment of goodwill, the Company determines the implied fair value of goodwill. If the carrying value of goodwill exceeds its implied fair value, an impairment loss is recorded. The Company's annual impairment tests of goodwill and other indefinite-lived intangibles in 2015, 2014 and 2013 resulted in no impairment charges.

Other Current Assets

Other current assets consisted of the following (in thousands):

	As of December 31,	
	2015	2014
Prepaid expenses	$21,817	$11,746
Other receivables	17,518	12,713
Insurance receivable – current portion	5,290	3,500
Workers' compensation deposits – current portion	7,500	4,800
Income taxes receivable	6,540	3,399
Inventory	4,681	3,249
Other	3,549	2,163
Other current assets	$66,895	$41,570

Other Accrued Liabilities

Other accrued liabilities consisted of the following (in thousands):

	As of December 31,	
	2015	2014
Accrued interest	$26,132	$13,013
Insurance liability – current portion	10,490	4,239
Other current liabilities	7,499	725
Income taxes payable	7,367	148
Contingent consideration	667	3,000
Accrued property taxes	2,951	2,069
Other	17,700	7,762
Other accrued liabilities	$72,806	$30,956

Stock Compensation

The Company measures and recognizes the cost of employee services received in exchange for awards of equity instruments based on the grant-date fair value in accordance with Financial Accounting Standards Board ("FASB") Accounting Standards Codification ("ASC") Topic 718, "*Compensation—Stock Compensation*." The Company uses the Black-Scholes valuation model to determine grant-date fair value for equity awards and uses straight-line amortization of share-based compensation expense over the requisite service period of the respective awards.

Earnings Per Share

Basic and diluted earnings per share are calculated in accordance with FASB ASC 260, "*Earnings Per Share*," based on the weighted-average number of shares outstanding in each period and dilutive stock options, non-vested shares and warrants, to the extent such securities have a dilutive effect on earnings per share.

Income Taxes

The Company uses the asset and liability method of accounting for income taxes. Under this method, deferred income taxes reflect the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes and net operating loss and tax credit carryforwards. The amount of deferred taxes on these temporary differences is determined using the tax rates that are expected to apply to the period when the asset is realized or the liability is settled, as applicable, based on tax rates and laws in the respective tax jurisdiction enacted as of the balance sheet date.

The Company reviews its deferred tax assets for recoverability and establishes a valuation allowance based on historical taxable income, projected future taxable income, applicable tax strategies, and the expected timing of the reversals of existing temporary differences. A valuation allowance is provided when it is more likely than not that some portion or all of the deferred tax assets will not be realized.

The Company records a liability for unrecognized tax benefits resulting from uncertain tax positions taken or expected to be taken in a tax return. The Company recognizes interest and penalties, if any, related to unrecognized tax benefits in income tax expense.

Recent Accounting Pronouncements

In November 2015, the Financial Accounting Standards Board (the "FASB") issued Accounting Standards Update ("ASU") 2015-17, *"Balance Sheet Classification of Deferred Taxes"* ("ASU 2015-17"). ASU 2015-17 simplifies the presentation for deferred income taxes by requiring that deferred tax liabilities and assets be classified as noncurrent in a classified statement of financial position. Although this guidance has an effective date for public companies for annual periods beginning after December 15, 2016, the Company has elected early adoption prospectively, as permitted, as of December 13, 2015. As such, the consolidated balance sheet as of December 31, 2014 was not retrospectively adjusted.

In September 2015, the FASB issued ASU 2015-16, *"Business Combinations (Subtopic 805-10)"* ("ASU 2015-16"). ASU 2015-16 simplifies the accounting for measurement-period adjustments by eliminating the requirement for an acquirer in a business combination to account for measurement-period adjustments retrospectively. Acquirers will recognize measurement-period adjustments during the period in which they determine the amounts, including the effect on earnings of any amounts they would have recorded in previous periods if the accounting had been completed at the acquisition date. Although this guidance has an effective date for public companies for fiscal years, and interim periods within those years, beginning after December 15, 2015, the Company has elected early adoption as permitted in the current period. There was no significant impact on the Company's consolidated financial statements as a result of the adoption.

In April 2015, the FASB issued ASU 2015-03, *"Interest-Imputation of Interest (Subtopic 835-30)"* ("ASU 2015-03"). ASU 2015-03 simplifies the presentation of debt issuance costs by requiring debt issuance costs related to a recognized debt liability be presented in the balance sheet as a direct deduction from the carrying amount of that debt liability, consistent with debt discounts. ASU 2015-03 is effective for fiscal years, and interim periods within those years, beginning after December 15, 2015. Early adoption is permitted, and the new guidance should be applied retrospectively. The Company has elected early adoption, as permitted, as of December 31, 2015 with retrospective application to December 31, 2014.

In May 2014, the FASB and the International Accounting Standards Board issued ASU 2014-09, *"Revenue from Contracts with Customers (Topic 606)"* ("ASU 2014-09"). ASU 2014-09's core principal is that a company will recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods or services. ASU 2014-09 is effective for fiscal years, and interim periods within those years, beginning after December 15, 2017. Additionally, ASU 2014-09 would permit both public and nonpublic organizations to adopt the new revenue standard early, but not before the original public organization effective date (that is, annual periods beginning after December 15, 2016). Management is evaluating the impact of ASU 2014-09 on the Company's consolidated financial statements.

3. Earnings Per Share

The following table sets forth the computation of basic and diluted earnings (loss) per share for the years ended December 31, 2015, 2014 and 2013 (in thousands except per share amounts):

	Year Ended December 31,		
	2015	2014	2013
Numerator:			
Basic and diluted earnings (loss) per share attributable to Acadia Healthcare Company, Inc.:			
Income from continuing operations	$112,443	$83,232	$43,270
Income (loss) from discontinued operation	111	(192)	(691)
Net income attributable to Acadia Healthcare Company, Inc.	$112,554	$83,040	$42,579
Denominator:			
Weighted average shares outstanding for basic earnings per share	68,085	55,063	50,004
Effects of dilutive instruments	306	264	257
Shares used in computing diluted earnings per common share	68,391	55,327	50,261
Basic earnings (loss) per share attributable to Acadia Healthcare Company, Inc.:			
Income from continuing operations	$ 1.65	$ 1.51	$ 0.87
Loss from discontinued operations	—	—	(0.02)
Net income attributable to Acadia Healthcare Company, Inc.:	$ 1.65	$ 1.51	$ 0.85
Diluted earnings (loss) per share attributable to Acadia Healthcare Company, Inc.:			
Income from continuing operations	$ 1.64	$ 1.50	$ 0.86
Loss from discontinued operations	—	—	(0.01)
Net income attributable to Acadia Healthcare Company, Inc.:	$ 1.64	$ 1.50	$ 0.85

Approximately 0.8 million, 0.7 million and 0.6 million shares of common stock issuable upon exercise of outstanding stock options were excluded from the calculation of diluted earnings per share for the year ended December 31, 2015, 2014 and 2013, respectively, because their effect would have been anti-dilutive.

4. Acquisitions

U.S. Acquisitions

On December 1, 2015, the Company completed the acquisition of certain facilities from MMO Behavioral Health Systems ("MMO"), including two acute inpatient behavioral health facilities with a total of 80 beds located in Jennings and Covington, Louisiana, for cash consideration of approximately $20.2 million.

On November 1, 2015, the Company completed the acquisitions of (i) Discovery House for cash consideration of approximately $118.5 million and (ii) Duffy's for cash consideration of approximately $29.6 million. Discovery House operates 19 comprehensive treatment centers located in four states. Duffy's is a substance abuse facility with 61 beds located in Calistoga, California.

On August 31, 2015, the Company completed the acquisition of a controlling interest in Southcoast Behavioral ("Southcoast"), an inpatient psychiatric facility located in Fairhaven, Massachusetts. The Company owns 75% of the equity interests in the facility. The value of the 25% noncontrolling interest approximates $9.2 million. The Company considered an income approach and other valuation methodologies to value the noncontrolling interests. The Company consolidates the operations of the facility based on its 75% equity ownership and its management of the entity. The noncontrolling interests are reflected as redeemable noncontrolling interests on the accompanying condensed consolidated balance sheet based on a put right that could require the Company to purchase the noncontrolling interests upon the occurrence of a change in control.

On July 1, 2015, the Company completed the acquisition of the assets of Belmont Behavioral Health ("Belmont"), an inpatient psychiatric facility with 147 beds located in Philadelphia, Pennsylvania for cash consideration of approximately $38.2 million which consists of $35.0 million base purchase price and an estimated working capital settlement of $3.2 million.

On March 1, 2015, the Company acquired the stock of Quality Addiction Management, Inc. ("QAM") for total consideration of approximately $54.8 million. QAM operates seven comprehensive treatment centers located in Wisconsin.

On February 11, 2015, the Company completed its acquisition of CRC Health Group, Inc. ("CRC") for total consideration of approximately $1.3 billion. As consideration for the acquisition, the Company issued 5,975,326 shares of its common stock to certain holders of CRC common stock and repaid CRC's outstanding indebtedness of $904.5 million. CRC is a leading provider of treatment services related to substance abuse and other addiction and behavioral disorders. At the acquisition date, CRC operated 35 inpatient facilities with over 2,400 beds and 81 comprehensive treatment centers located in 30 states.

U.K. Acquisitions

On November 1, 2015, the Company completed the acquisition of Cleveland House, an inpatient psychiatric facility with 32 beds located in England, for approximately $10.3 million.

On October 1, 2015, the Company completed the acquisition of Meadow View, an inpatient psychiatric facility with 28 beds located in England, for cash consideration of approximately $6.8 million.

On September 1, 2015, the Company completed the acquisitions of (i) three facilities from The Danshell Group ("Danshell") for approximately $59.8 million, (ii) two facilities from Health and Social Care Partnerships ("H&SCP") for approximately $26.2 million and (iii) Manor Hall for approximately $14.0 million. The inpatient psychiatric facilities acquired from Danshell have an aggregate of 73 beds and are located in England. The inpatient psychiatric facilities acquired from H&SCP have an aggregate of 50 beds and are located in England. Manor Hall has 26 beds and is located in England.

On July 1, 2015, the Company completed the acquisition of The Manor Clinic, a substance abuse facility with 15 beds located in England, for cash consideration of approximately $5.9 million.

On June 1, 2015, the Company completed the acquisitions of (i) one facility from Choice Lifestyles ("Choice") for approximately $25.9 million and (ii) 15 facilities from Care UK Limited ("Care UK") for approximately $88.2 million. The inpatient psychiatric facility acquired from Choice has 42 beds and is located in England. The inpatient psychiatric facilities acquired from Care UK have an aggregate of 299 beds and are located in England.

On April 1, 2015, the Company completed the acquisitions of (i) two facilities from Choice for approximately $37.5 million, (ii) Pastoral Care Group ("Pastoral") for approximately $34.2 million and (iii) Mildmay Oaks f/k/a Vista Independent Hospital ("Mildmay Oaks") for approximately $14.9 million. The two inpatient psychiatric facilities acquired from Choice have an aggregate of 48 beds and are located in England. Pastoral operates two inpatient psychiatric facilities with an aggregate of 65 beds located in Wales. Mildmay Oaks is an inpatient psychiatric facility with 67 beds located in England.

2014 Acquisitions

On December 1, 2014, the Company acquired the assets of Croxton Warwick Lodge ("Croxton"), an inpatient psychiatric facility with 24 beds located in England, for cash consideration of $15.6 million. On December 31, 2014, the Company completed the acquisition of Skyway House ("Skyway"), a substance abuse facility with 28 beds located in Chico, California, for cash consideration of $0.3 million. On September 3, 2014, the Company completed the acquisition of McCallum Place ("McCallum"), an eating disorder treatment facility with 85 beds offering residential, partial hospitalization and intensive outpatient treatment programs located in St. Louis, Missouri, and Austin, Texas, for total consideration of $37.4 million. On July 1, 2014, the Company acquired Partnerships in Care for cash consideration of $661.7 million, which was net of cash acquired of $12.0 million and the gain on settlement of foreign currency derivatives of $15.3 million. At the acquisition date, Partnerships in Care was the second largest independent provider of inpatient behavioral healthcare services in the United Kingdom, operating 23 inpatient behavioral healthcare facilities with over 1,200 beds. On January 1, 2014, the Company acquired the assets of Pacific Grove Hospital ("Pacific Grove"), an inpatient psychiatric facility with 68 beds located in Riverside, California, for cash consideration of $10.5 million.

Summary of Acquisitions

The Company selectively seeks opportunities to expand and diversify its base of operations by acquiring additional facilities. Approximately $326.1 million of the goodwill associated with domestic acquisitions completed in 2015 and 2014 is deductible for federal income tax purposes. The fair values assigned to certain assets and liabilities assumed by the Company have been estimated on a preliminary basis and are subject to change as new facts and circumstances emerge that were present at the date of acquisition. Specifically, the Company is further assessing the valuation of certain real property and intangible assets and certain tax matters as well as certain receivables and assumed liabilities of MMO, Discovery House, Duffy's, Cleveland House, Meadow View, Danshell, H&SCP, Manor Hall, The Manor Clinic, Belmont, Choice, Care UK, Pastoral, Mildmay Oaks, QAM and CRC.

The preliminary fair values of assets acquired and liabilities assumed, at the corresponding acquisition dates, during the year ended December 31, 2015 in connection with 2015 acquisitions were as follows (in thousands):

	CRC	Other	Total
Cash	$ 19,599	$ 5,417	$ 25,016
Accounts receivable	47,018	27,191	74,209
Prepaid expenses and other current assets	11,979	2,957	14,936
Property and equipment	137,555	273,143	410,698
Goodwill	1,042,521	313,680	1,356,201
Intangible assets	37,000	204	37,204
Deferred tax asset-noncurrent	88,857	—	88,857
Other assets	6,478	51	6,529
Total assets acquired	1,391,007	622,643	2,013,650
Accounts payable	4,740	4,477	9,217
Accrued salaries and benefits	14,827	3,687	18,514
Other accrued expenses	38,677	5,291	43,968
Deferred tax liabilities – noncurrent	—	13,619	13,619
Debt	904,467	—	904,467
Other liabilities	34,720	10	34,730
Total liabilities assumed	997,431	27,084	1,024,515
Redeemable noncontrolling interests	—	9,132	9,132
Net assets acquired	$ 393,576	$586,427	$ 980,003

The fair values of assets acquired and liabilities assumed during 2014, at the corresponding acquisition dates, were as follows (in thousands):

	Partnerships in Care	Other	Total
Cash	$ 11,674	$ —	$ 11,674
Accounts receivable	7,684	1,849	9,533
Prepaid expenses and other current assets	8,828	169	8,997
Property and equipment	610,477	27,203	637,680
Goodwill	92,959	32,232	125,191
Intangible assets	651	204	855
Other assets	6,897	3,240	10,137
Total assets acquired	739,170	64,897	804,067
Accounts payable	3,958	93	4,051
Accrued salaries and benefits	10,422	—	10,422
Other accrued expenses	7,166	1,014	8,180
Deferred tax liabilities – noncurrent	21,369	—	21,369
Other liabilities	7,704	—	7,704
Total liabilities assumed	50,619	1,107	51,726
Net assets acquired	$ 688,551	$63,790	$752,341

Other

The qualitative factors comprising the goodwill acquired in the Pacific Grove, Partnerships in Care, McCallum, Croxton, Skyway, CRC, QAM, Choice, Pastoral, Mildmay Oaks, Care UK, The Manor Clinic, Belmont, Southcoast, Danshell, H&SCP, Manor Hall, Meadow View, Cleveland House, Duffy's, Discovery House and MMO acquisitions (collectively the "2014 and 2015 Acquisitions") include efficiencies derived through synergies expected by the elimination of certain redundant corporate functions and expenses, the ability to leverage call center referrals to a broader provider base, coordination of services provided across the combined network of facilities, achievement of operating efficiencies by benchmarking performance, and applying best practices throughout the combined companies.

Table of Contents

Transaction-related expenses comprised the following costs for the years ended December 31, 2015, 2014 and 2013 (in thousands):

	Year Ended December 31,		
	2015	2014	2013
Advisory and financing commitment fees	$10,337	$ —	$ —
Legal, accounting and other fees	17,768	12,836	5,535
Severance and contract termination costs	8,466	814	1,615
	$36,571	$13,650	$7,150

Priory Acquisition

On February 16, 2016, the Company completed its acquisition of Priory Group No. 1 Limited ("Priory") for a total purchase price of approximately $2.2 billion, including total cash consideration of approximately $1.9 billion and 4,033,561 shares of its common stock. Priory is the leading independent provider of behavioral healthcare services in the United Kingdom.

The preliminary fair values of assets acquired and liabilities assumed in connection with the Priory acquisition are estimated as follows (in thousands). As the acquisition was recently completed on February 16, 2016, these amounts have been estimated on a preliminary basis and are subject to change as the acquisition method of accounting is finalized.

Cash	$ 23,000
Accounts receivable	62,000
Prepaid expenses and other current assets	15,000
Property and equipment	1,582,000
Goodwill	554,500
Intangible assets	37,500
Deferred tax assets - noncurrent	31,000
Total assets acquired	2,305,000
Accounts payable	82,000
Accrued salaries and benefits	26,000
Other accrued expenses	6,000
Long-term debt	1,348,400
Other liabilities	35,000
Total liabilities assumed	1,497,400
Net assets acquired	$ 807,600

Pro Forma Information

The consolidated statements of income for the year ended December 31, 2015 included revenue of $883.2 million and income from continuing operations before income taxes of $138.1 million for acquisitions completed in 2015. The consolidated statements of income for the year ended December 31, 2014 included revenue of $161.4 million and income from continuing operations before income taxes of $11.3 million for acquisitions completed in 2014.

The following table provides certain pro forma financial information for the Company as if the 2014 and 2015 Acquisitions and the Priory acquisition occurred as of January 1, 2014 (in thousands):

	Year Ended December 31,	
	2015	2014
Revenue	$2,851,695	$2,731,176
Income from continuing operations, before income taxes	$ 91,383	$ 76,491

Table of Contents

5. Other Intangible Assets

Other identifiable intangible assets and related accumulated amortization consisted of the following as of December 31, 2015 and 2014 (in thousands):

	Gross Carrying Amount		Accumulated Amortization	
	December 31, 2015	December 31, 2014	December 31, 2015	December 31, 2014
Intangible assets subject to amortization:				
Contract intangible assets	$ 2,100	$ 2,100	$ (1,750)	$ (1,330)
Non-compete agreements	1,247	1,247	(1,247)	(1,155)
	3,347	3,347	(2,997)	(2,485)
Intangible assets not subject to amortization:				
Licenses and accreditations	11,479	9,184	—	—
Trade names	37,800	3,000	—	—
Certificates of need	9,946	8,590	—	—
	59,225	20,774	—	—
Total	$ 62,572	$ 24,121	$ (2,997)	$ (2,485)

Amortization expense related to definite-lived intangible assets was $0.5 million, $0.6 million and $0.8 million for the years ended December 31, 2015, 2014 and 2013, respectively. Estimated amortization expense for the years ending December 31, 2016, 2017, 2018, 2019 and 2020 is $0.4 million, $0 million, $0 million, $0 and $0, respectively. The Company's licenses and accreditations, trade names and certificate of need intangible assets have indefinite lives and are, therefore, not subject to amortization.

6. Discontinued Operations

The results of operations of certain terminated management contracts have been reported as discontinued operations in the accompanying consolidated financial statements.

A summary of results from discontinued operations is as follows (in thousands):

	Year Ended December 31,		
	2015	2014	2013
Revenue	$—	$—	$—
Net income (loss) from discontinued operations, net of income taxes	$111	$(192)	$(691)

7. Long-Term Debt

Long-term debt consisted of the following (in thousands):

	December 31, 2015	December 31, 2014
Amended and Restated Senior Credit Facility:		
Senior Secured Term A Loans	$ 500,750	$ 527,500
Senior Secured Term B Loans	495,000	—
Senior Secured Revolving Line of Credit	158,000	—
12.875% Senior Notes due 2018	—	97,500
6.125% Senior Notes due 2021	150,000	150,000
5.125% Senior Notes due 2022	300,000	300,000
5.625% Senior Notes due 2023	650,000	—
9.0% and 9.5% Revenue Bonds	22,410	22,625
Less: unamortized debt issuance costs, discount and premium	(35,416)	(17,990)
	2,240,744	1,079,635
Less: current portion	(45,360)	(26,965)
Long-term debt	$ 2,195,384	$ 1,052,670

Amended and Restated Senior Credit Facility

The Company entered into a senior secured credit facility (the "Senior Secured Credit Facility") on April 1, 2011. On December 31, 2012, the Company entered into an Amended and Restated Credit Agreement (the "Amended and Restated Credit Agreement") which amended and restated the Senior Secured Credit Facility ("Amended and Restated Senior Credit Facility").

On February 13, 2014, the Company entered into a Fourth Amendment (the "Fourth Amendment") to the Amended and Restated Credit Agreement, to increase the size of the Amended and Restated Senior Credit Facility and extend the maturity date thereof, which resulted in the Company having a revolving line of credit of up to $300.0 million and term loans of $300.0 million. The Fourth Amendment also reduced the interest rates applicable to the Amended and Restated Senior Credit Facility and provided increased flexibility to the Company in terms of the financial and other restrictive covenants. The Fourth Amendment also provides for a $150.0 million incremental credit facility, with the potential for unlimited additional incremental amounts, provided the Company meets certain financial ratios, in each case subject to customary conditions precedent to borrowing.

On June 16, 2014, the Company entered into a Fifth Amendment (the "Fifth Amendment") to the Amended and Restated Credit Agreement. The Fifth Amendment specifically permitted the Company's acquisition of Partnerships in Care, gave the Company the ability to incur a tranche of term loan B debt in the future through its incremental credit facility, and modified certain of the restrictive covenants on miscellaneous investments and incurrence of miscellaneous liens. Finally, the Fifth Amendment provided increased flexibility to the Company in terms of its financial covenants.

On December 15, 2014, the Company entered into a Sixth Amendment (the "Sixth Amendment") to our Amended and Restated Credit Agreement. Pursuant to the Sixth Amendment, the Company incurred $235.0 million of additional term loans. A portion of the additional term loan advance was used to prepay its outstanding revolving loans, and a portion of the additional term loan advance is being held as cash on the consolidated balance sheet. The Sixth Amendment also specifically permitted the acquisition of CRC. In connection with the acquisition of CRC, the Sixth Amendment (i) imposed a temporary reserve on the Company's revolving credit facility in the amount of $110.0 million in order to preserve such reserved amounts for later borrowings to partially fund the consideration for the acquisition of CRC (subject to limited conditionality provisions) (the reserve is no longer in effect due to the acquisition of CRC), (ii) permitted the incurrence of an additional incremental term loan facility under the Amended and Restated Credit Agreement partially to fund the consideration for the acquisition of CRC (subject to limited conditionality provisions) and (iii) permitted the issuance of additional senior unsecured indebtedness or senior unsecured bridge indebtedness partially to fund the consideration for the acquisition of CRC.

The Sixth Amendment also permits the Company, subject to certain consents, to add one or more foreign borrowers and/or request revolving loans and letters of credit in foreign currencies.

On February 6, 2015, the Company entered into a Seventh Amendment (the "Seventh Amendment") to our Amended and Restated Credit Agreement. The Seventh Amendment added Citibank, N.A. as an "L/C Issuer" under the Amended and Restated Credit Agreement in order to permit the rollover of CRC's existing letters of credit into the Amended and Restated Credit Agreement and increased both the Company's Letter of Credit Sublimit and Swing Line Sublimit to $20.0 million.

On February 11, 2015, the Company entered into a First Incremental Facility Amendment (the "First Incremental Amendment") to our Amended and Restated Credit Agreement. The First Incremental Amendment activated a new $500.0 million incremental Term Loan B facility (the "TLB Facility") that was added to our Amended and Restated Senior Credit Facility, subject to limited conditionality provisions. Borrowings under the TLB Facility were used to fund a portion of the purchase price for the acquisition of CRC.

On April 22, 2015, the Company entered into an Eighth Amendment (the "Eighth Amendment") to our Amended and Restated Credit Agreement. The Eighth Amendment changed the definition of "Change of Control" in part to remove a provision whose purpose was, when calculating whether a majority of incumbent directors have approved new directors, that any incumbent director that became a director as a result of a threatened or actual proxy contest was not counted in such calculation.

On January 25, 2016, the Company entered into the Ninth Amendment (the "Ninth Amendment") to the Amended and Restated Senior Credit Facility. The Ninth Amendment modifies certain definitions and provides increased flexibility to the Company in terms of its financial covenants. Our baskets for permitted investments were also increased to provide increased flexibility for us to invest in non-wholly owned subsidiaries, joint ventures and foreign subsidiaries. We may now invest in non-wholly owned subsidiaries and joint ventures up to 10.0% of our and our subsidiaries' total assets in any four consecutive fiscal quarter period, and up to 12.5% of our and our subsidiaries' total assets during the term of the Amended and Restated Credit Agreement. We may also invest in foreign subsidiaries that are not loan parties up to 10% of our and our subsidiaries' total assets in any consecutive four fiscal quarter period, and up to 15% of our and our subsidiaries' total assets during the term of the Amended and Restated Credit Agreement. The foregoing permitted investments are subject to an aggregate cap of 25% of our and our subsidiaries' total assets in any fiscal year.

On February 16, 2016, the Company entered into a Second Incremental Facility Amendment (the "Second Incremental Amendment") to our Amended and Restated Credit Agreement. The Second Incremental Amendment activated a new $955.0 million incremental Term Loan B facility (the "New TLB Facility") and added $135.0 million to the Term Loan A facility (the "TLA Facility") to the Amended and Restated Senior Secured Credit Facility, subject to limited conditionality provisions. Borrowings under the New TLB Facility were used to fund a portion of the purchase price for the acquisition of Priory and the fees and expenses for such acquisition and the related financing transactions. Borrowings under the TLA Facility were used to pay down the majority of our $300.0 million revolving credit facility.

The Company had $135.7 million of availability under the revolving line of credit as of December 31, 2015. Borrowings under the revolving line of credit are subject to customary conditions precedent to borrowing. The Amended and Restated Credit Agreement requires quarterly term loan principal repayments of our TLA Facility of $10.0 million for March 31, 2016 to December 31, 2016, $13.4 million for September 30, 2017 to December 31, 2017, and $16.7 million for March 31, 2018 to December 31, 2018, with the remaining principal balance of the TLA Facility due on the maturity date of February 13, 2019. On December 15, 2014, prior to the execution of the Sixth Amendment, the Company prepaid the December 31, 2014 quarterly term loan principal payment of $1.9 million. The Company is required to repay the Existing TLB Facility in equal quarterly installments of $1.3 million on the last business day of each March, June, September and December, with the outstanding principal balance of the Existing TLB Facility due on February 11, 2022. The Company is required to repay the New TLB Facility in equal quarterly installments of approximately $2.4 million on the last business day of each March, June, September and December, with the outstanding principal balance of the TLB Facility due on February 16, 2023.

Borrowings under the Amended and Restated Senior Credit Facility are guaranteed by each of the Company's wholly-owned domestic subsidiaries (other than certain excluded subsidiaries) and are secured by a lien on substantially all of the assets of the Company and such subsidiaries. Borrowings with respect to the TLA Facility and the Company's revolving credit facility (collectively, "Pro Rata Facilities") under the Amended and Restated Credit Agreement bear interest at a rate tied to Acadia's Consolidated Leverage Ratio (defined as consolidated funded debt net of up to $40.0 million of unrestricted and unencumbered cash to consolidated EBITDA, in each case as defined in the Amended and Restated Credit Agreement). The Applicable Rate (as defined in the Amended and Restated Credit Agreement) for the Pro Rata Facilities was 3.0% for Eurodollar Rate Loans (as defined in the Amended and Restated Credit Agreement) and 2.25% for Base Rate Loans (as defined in the Amended and Restated Credit Agreement) at December 31, 2015. Eurodollar Rate Loans with respect to the Pro Rata Facilities bear interest at the Applicable Rate plus the Eurodollar Rate (as defined in the Amended and Restated Credit Agreement) (based upon the LIBOR Rate (as defined in the Amended and Restated Credit Agreement) prior to commencement of the interest rate period). Base Rate Loans with respect to the Pro Rata Facilities bear interest at the Applicable Rate plus the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate and (iii) the Eurodollar Rate plus 1.0%. As of December 31, 2015, the Pro Rata Facilities bore interest at a rate of LIBOR plus 3.0%. In addition, the Company is required to pay a commitment fee on undrawn amounts under the revolving line of credit.

The Amended and Restated Credit Agreement requires the Company and its subsidiaries to comply with customary affirmative, negative and financial covenants, including a fixed charge coverage ratio, consolidated leverage ratio and senior secured leverage ratio. The Company may be required to pay all of its indebtedness immediately if it defaults on any of the numerous financial or other restrictive covenants contained in any of its material debt agreements. As of December 31, 2015, the Company was in compliance with such covenants.

Senior Notes

12.875% Senior Notes due 2018

On November 1, 2011, the Company issued $150.0 million of 12.875% Senior Notes due 2018 (the "12.875% Senior Notes") at 98.323% of the aggregate principal amount of $150.0 million, a discount of $2.5 million. The notes bear interest at a rate of 12.875% per annum. The Company pays interest on the notes semi-annually, in arrears, on November 1 and May 1 of each year.

On March 12, 2013, the Company redeemed $52.5 million in principal amount of the 12.875% Senior Notes using a portion of the net proceeds of its December 2012 equity offering pursuant to the provision in the indenture permitting an optional redemption with equity proceeds of up to 35% of the principal amount of 12.875% Senior Notes. The 12.875% Senior Notes were redeemed at a redemption price of 112.875% of the principal amount thereof plus accrued and unpaid interest to, but not including, the redemption date in accordance with the provisions of the indenture governing the 12.875% Senior Notes. As part of the redemption of 35% of the 12.875% Senior Notes, the Company recorded a debt extinguishment charge of $9.4 million, including the premium and write-off of deferred financing costs, which was recorded in debt extinguishment costs in the consolidated statements of income.

On September 21, 2015, the Company purchased approximately $88.3 million aggregate principal amount of 12.875% Senior Notes in connection with a tender offer for any and all of the 12.875% Senior Notes. The notes purchased represent 90.6% of the outstanding $97.5 million principal amount of 12.875% Senior Notes. The 12.875% Senior Notes were purchased at a price of 107.875% of the principal amount thereof plus accrued and unpaid interest to, but not including, September 21, 2015. On September 18, 2015, the Company delivered a notice to redeem all $9.2 million in principal amount of the 12.875% Senior Notes remaining outstanding following the consummation of the tender offer. The redemption was effective November 1, 2015 with payment made to the note holders on November 2, 2015. The Company redeemed the remaining 12.875% Senior Notes in accordance to their terms, and therefore no debt remains outstanding under the 12.875% Senior Notes. In connection with the purchase of notes, the Company recorded a debt extinguishment charge of approximately $10.8 million at the year ended December 31, 2015, including the premium and write-off of deferred financing costs, which was recorded in debt extinguishment costs in the accompanying consolidated statements of income.

6.125% Senior Notes due 2021

On March 12, 2013, the Company issued $150.0 million of 6.125% Senior Notes due 2021 (the "6.125% Senior Notes"). The 6.125% Senior Notes mature on March 15, 2021 and bear interest at a rate of 6.125% per annum, payable semi-annually in arrears on March 15 and September 15 of each year.

5.125% Senior Notes due 2022

On July 1, 2014, the Company issued $300.0 million of 5.125% Senior Notes due 2022 (the "5.125% Senior Notes"). The 5.125% Senior Notes mature on July 1, 2022 and bear interest at a rate of 5.125% per annum, payable semi-annually in arrears on January 1 and July 1 of each year, beginning on January 1, 2015.

5.625% Senior Notes due 2023

On February 11, 2015, the Company issued $375.0 million of 5.625% Senior Notes due 2023 (the "5.625% Senior Notes"). The 5.625% Senior Notes mature on February 15, 2023 and bear interest at a rate of 5.625% per annum, payable semi-annually in arrears on February 15 and August 15 of each year, beginning on August 15, 2015.

On September 21, 2015, the Company issued $275.0 million of additional 5.625% Senior Notes. The additional notes form a single class of debt securities with the existing 5.625% Senior Notes. Giving effect to this issuance, the Company has outstanding an aggregate of $650.0 million of 5.625% Senior Notes.

6.500% Senior Notes due 2024

On February 16, 2016, we issued $390.0 million of 6.500% Senior Notes due 2024 (the "6.500% Senior Notes"). The 6.500% Senior Notes mature on March 1, 2024 and bear interest at a rate of 6.500% per annum, payable semi-annually in arrears on March 1 and September 1 of each year, beginning on September 1, 2016.

The indentures governing the 6.125% Senior Notes, 5.125% Senior Notes, 5.625% Senior Notes and 6.500% Senior Notes (together, the "Senior Notes") contain covenants that, among other things, limit the Company's ability and the ability of its restricted subsidiaries to: (i) pay dividends, redeem stock or make other distributions or investments; (ii) incur additional debt or issue certain preferred stock; (iii) transfer or sell assets; (iv) engage in certain transactions with affiliates; (v) create restrictions on dividends or other payments by the restricted subsidiaries; (vi) merge, consolidate or sell substantially all of the Company's assets; and (vii) create liens on assets.

The Senior Notes issued by the Company are guaranteed by each of the Company's subsidiaries that guarantee the Company's obligations under the Amended and Restated Senior Credit Facility. The guarantees are full and unconditional and joint and several.

The Company may redeem the Senior Notes at its option, in whole or part, at the dates and amounts set forth in the indentures.

9.0% and 9.5% Revenue Bonds

On November 11, 2012, in connection with the acquisition of Park Royal, the Company assumed debt of $23.0 million. The fair market value of the debt assumed was $25.6 million and resulted in a debt premium balance being recorded as of the acquisition date. The debt consisted of $7.5 million and $15.5 million of Lee County (Florida) Industrial Development Authority Healthcare Facilities Revenue Bonds, Series 2010 with stated interest rates of 9.0% and 9.5% ("9.0% and 9.5% Revenue Bonds"), respectively. The 9.0% bonds in the amount of $7.5 million have a maturity date of December 1, 2030 and require yearly principal payments beginning in 2013. The 9.5% bonds in the amount of $15.5 million have a maturity date of December 1, 2040 and require yearly principal payments beginning in 2031. The principal payments establish a bond sinking fund to be held with the trustee and shall be sufficient to redeem the principal amounts of the 9.0% and 9.5% Revenue Bonds on their respective maturity dates. As of December 31, 2015 and 2014, $2.3 million was recorded within other assets on the balance sheet related to the debt service reserve fund requirements. The yearly principal payments, which establish a bond sinking fund, will increase the debt service reserve fund requirements. The bond premium amount of $2.6 million is amortized as a reduction of interest expense over the life of the revenue bonds using the effective interest method.

Debt Issuance Costs

Debt issuance costs are deferred and amortized to interest expense over the term of the related debt. Debt issuance costs at December 31, 2015 were $37.6 million, net of accumulated amortization of $12.6 million. Debt issuance costs at December 31, 2014 were $20.9 million, net of accumulated amortization of $9.5 million. Amortization expense related to debt issuance costs, which is reported as interest expense, was $7.1 million and $3.2 million, respectively, for the years ended December 31, 2015 and 2014. Estimated amortization of debt issuance costs for the years ending December 31, 2016, 2017, 2018, 2019 and 2020 is $6.5 million, $6.6 million, $6.7 million, $5.1 million and $5.2 million, respectively.

Other

The aggregate maturities of long-term debt as of December 31, 2015 were as follows (in thousands):

2016	$ 45,360
2017	58,755
2018	72,155
2019	345,555
2020	5,330
Thereafter	1,749,005
Total	$2,276,160

In connection with the acquisition of Priory on February 16, 2016, the Company borrowed $955.0 million under its New TLB Facility, issued $390.0 million of 6.500% Senior Notes and borrowed $135.0 million under the TLA Facility. The aggregate maturities of the long-term debt following the acquisition of Priory on February 16, 2016 were as follows (in thousands):

2016	$ 65,035
2017	81,805
2018	98,580
2019	449,605
2020	14,880
Thereafter	2,903,255
Total	$3,613,160

8. Equity

Preferred Stock

The Company's amended and restated certificate of incorporation provides that up to 10,000,000 shares of preferred stock may be issued. The Board of Directors has the authority to issue preferred stock in one or more series and to fix for each series the voting powers (full, limited or none), and the designations, preferences and relative participating, optional or other special rights and qualifications, limitations or restrictions on the stock and the number of shares constituting any series and the designations of this series, without any further vote or action by the stockholders.

Common Stock

The Company's amended and restated certificate of incorporation currently provides that up to 90,000,000 shares of common stock may be issued. Holders of the Company's common stock are entitled to one vote for each share held of record on all matters on which stockholders may vote. There are no preemptive, conversion, redemption or sinking fund provisions applicable to shares of the Company's common stock. In the event of liquidation, dissolution or winding up, holders of the Company's common stock are entitled to share ratably in the assets available for distribution, subject to any prior rights of any holders of preferred stock then outstanding. Delaware law prohibits the Company from paying any dividends unless it has capital surplus or net profits available for this purpose. In addition, the Amended and Restated Senior Credit Facility imposes restrictions on the Company's ability to pay dividends.

In February 2016, the Company filed definitive proxy materials with the SEC related to the Company's Special Meeting of the Stockholders to be held on March 3, 2016, where the Company's stockholders will be asked to amend the Company's Amended and Restated Certificate of Incorporation to increase the number of authorized shares of its common stock from 90,000,000 shares to 180,000,000 shares.

Equity Offerings

On June 17, 2014, the Company completed the offering of 8,881,794 shares of common stock (including shares sold pursuant to the exercise of the over-allotment option that the Company granted to the underwriters as part of the offering) at a price of $44.00 per share. The net proceeds to the Company from the sale of the shares, after deducting the underwriting discount of $15.6 million and additional offering-related costs of $0.8 million, were $374.4 million. The Company used the net offering proceeds to fund a portion of the consideration for the acquisition of Partnerships in Care.

On February 11, 2015, the Company completed its acquisition of CRC for total consideration of approximately $1.3 billion. As consideration for the acquisition, the Company issued 5,975,326 shares of its common stock to certain holders of CRC common stock and repaid CRC's outstanding indebtedness.

On May 11, 2015, the Company completed the offering of 5,175,000 shares of common stock (including shares sold pursuant to the exercise of the over-allotment option that the Company granted to the underwriters as part of the offering) at a price of $66.50 per share. The net proceeds to the Company from the sale of the shares, after deducting the underwriting discount of $12.0 million and additional offering-related costs of $0.8 million, were $331.3 million. The Company used the net offering proceeds to repay outstanding indebtedness and fund acquisitions.

On January 12, 2016, the Company completed the offering of 11,500,000 shares of common stock (including shares sold pursuant to the exercise of the over-allotment option that the Company granted to the underwriters as part of the offering) at a price of $61.00 per share. The net proceeds to the Company from the sale of the shares, after deducting the underwriting discount of $15.8 million and additional offering-related costs of $0.7 million, were $685.0 million. The Company used the net offering proceeds to fund a portion of the purchase price for the acquisition of Priory.

On February 16, 2016, the Company completed its acquisition of Priory for a total purchase price of approximately $2.2 billion including total cash consideration of approximately $1.9 billion and the issuance of 4,033,561 shares of our common stock.

9. Equity-Based Compensation

Equity Incentive Plans

The Company issues stock-based awards, including stock options, restricted stock and restricted stock units, to certain officers, employees and non-employee directors under the Acadia Healthcare Company, Inc. Incentive Compensation Plan (the "Equity Incentive Plan"). As of December 31, 2015, a maximum of 4,700,000 shares of the Company's common stock were authorized for issuance as stock options, restricted stock and restricted stock units or other share-based compensation under the Equity Incentive Plan, of which 1,921,673 were available for future grant. Stock options may be granted for terms of up to ten years. The Company recognizes expense on all share-based awards on a straight-line basis over the requisite service period of the entire award. Grants to employees generally vest in annual increments of 25% each year, commencing one year after the date of grant. The exercise prices of stock options are equal to the most recent closing price of the Company's common stock on the date of grant.

The Company recognized $20.5 million, $10.1 million and $5.2 million in equity-based compensation expense for the years ended December 31, 2015, 2014 and 2013, respectively. As of December 31, 2015, there was $47.9 million of unrecognized compensation expense related to unvested options, restricted stock and restricted stock units, which is expected to be recognized over the remaining weighted average vesting period of 1.4 years.

As of December 31, 2015, there were no warrants outstanding and exercisable. The Company recognized a deferred income tax benefit of $8.4 million and $4.1 million for the years ended December 31, 2015 and 2014, respectively, related to equity-based compensation expense. The actual tax benefit realized from stock options exercised during the years ended December 31, 2015, 2014 and 2013 was $0.3 million, $4.6 million and $1.8 million, respectively.

Stock option activity during 2014 and 2015 was as follows (aggregate intrinsic value in thousands):

	Number of Options	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term (in years)	Aggregate Intrinsic Value
Options outstanding at January 1, 2014	798,809	$ 21.93	8.20	$ 10,700
Options granted	226,663	49.80	9.25	209
Options exercised	(210,199)	14.93	N/A	4,994
Options cancelled	(77,851)	27.85	N/A	N/A
Options outstanding at December 31, 2014	737,422	32.19	8.09	14,512
Options granted	204,700	63.07	9.21	1,724
Options exercised	(214,079)	42.75	N/A	9,890
Options cancelled	(33,300)	46.53	N/A	N/A
Options outstanding at December 31, 2015	694,743	$ 42.87	7.70	$ 20,717
Options exercisable at December 31, 2014	91,947	$ 28.87	6.30	$ 3,326
Options exercisable at December 31, 2015	106,330	$ 36.41	5.83	$ 4,968

Restricted stock activity during 2014 and 2015 was as follows:

	Number of Shares	Weighted Average Grant-Date Fair Value
Unvested at January 1, 2014	461,697	$ 24.96
Granted	468,484	48.99
Cancelled	(75,369)	36.36
Vested	(132,784)	22.81
Unvested at December 31, 2014	722,028	$ 39.77
Granted	503,052	62.67
Cancelled	(44,900)	49.55
Vested	(235,618)	34.93
Unvested at December 31, 2015	944,562	$ 52.74

Restricted stock unit activity during 2014 and 2015 was as follows:

	Number of Units	Weighted Average Grant-Date Fair Value
Unvested at January 1, 2014	95,751	$ 23.05
Granted	108,449	50.75
Cancelled	—	—
Vested	(79,087)	21.81
Unvested at December 31, 2014	125,113	$ 38.73
Granted	217,994	61.77
Cancelled	—	—
Vested	(125,023)	32.38
Unvested at December 31, 2015	218,084	$ 56.97

The grant-date fair value of the Company's stock options is estimated using the Black-Scholes option pricing model. The following table summarizes the grant-date fair value of options and the assumptions used to develop the fair value estimates for options granted during the year ended December 31, 2015 and 2014:

	December 31, 2015	December 31, 2014
Weighted average grant-date fair value of options	$ 21.78	$ 17.14
Risk-free interest rate	1.5%	1.7%
Expected volatility	35%	36%
Expected life (in years)	5.5	5.5

The Company's estimate of expected volatility for stock options is based upon the volatility of guideline companies given the lack of sufficient historical trading experience of the Company's common stock. The risk-free interest rate is the approximate yield on United States Treasury Strips having a life equal to the expected option life on the date of grant. The expected life is an estimate of the number of years an option will be held before it is exercised.

10. Income Taxes

Income tax expense (benefit) from continuing operations consists of the following for the periods presented (in thousands):

	Year Ended December 31,		
	2015	2014	2013
Current:			
Federal	$ (218)	$30,834	$13,202
State	4,078	3,959	2,513
Foreign	5,915	914	177
Total current	9,775	35,707	15,892
Deferred:			
Federal	40,635	2,667	7,802
State	5,349	353	1,786
Foreign	(2,371)	4,195	495
Total deferred provision	43,613	7,215	10,083
Provision for (benefit from) income taxes	$53,388	$42,922	$25,975

The following table presents the income taxes associated with continuing operations and discontinued operations as reflected in the consolidated statements of income (in thousands):

	Year Ended December 31,		
	2015	2014	2013
Continuing operations	$53,388	$42,922	$25,975
Discontinued operations	(88)	(22)	(544)
Total	$53,300	$42,900	$25,431

A reconciliation of the U.S. federal statutory rate, from continuing operations, to the effective tax rate is as follows for the periods presented:

	Year Ended December 31,		
	2015	2014	2013
U.S. federal statutory rate on income before income taxes	35.0%	35.0%	35.0%
Impact of foreign operations (1)	(10.0)	(4.2)	(0.3)
State income taxes, net of federal tax effect	4.8	2.3	4.9
Permanent differences	4.2	1.1	0.8
Change in valuation allowance	1.2	(0.1)	(0.3)
Other	(2.8)	(0.1)	(2.6)
Effective income tax rate	32.4%	34.0%	37.5%

(1) Our effective tax rate reflects the benefit of having a portion of our operations outside the U.S., most of which are taxed at statutory rates lower than the statutory U.S. rate of 35%, the benefit of some income being partially exempt from income taxes due to various operating and financing activities and certain asset basis changes.

The tax effects of temporary differences that give rise to significant portions of the deferred tax assets and liabilities of the Company at December 31, 2015 and December 31, 2014 were as follows (in thousands):

	December 31,	
	2015	2014
Deferred tax assets:		
Net operating losses and tax credit carryforwards – federal and state	$ 47,695	$ 5,082
Bad debt allowance	14,050	9,028
Accrued compensation and severance	20,150	11,517
Pension reserves	536	1,975
Insurance reserves	15,449	4,621
Leases	2,675	850
Accrued expenses	5,324	41
Other assets	3,551	1,989
Total gross deferred tax assets	109,430	35,103
Less: valuation allowance	(16,571)	(4,734)
Deferred tax assets	92,859	30,369
Deferred tax liabilities:		
Fixed asset basis difference	(11,392)	(38,147)
Prepaid items	(3,113)	(1,705)
Intangible assets	(48,918)	(21,094)
Other liabilities	(4,258)	(7)
Total deferred tax liabilities	(67,681)	(60,953)
Total net deferred tax asset (liability)	$ 25,178	$(30,584)

The above amounts are classified as current or long-term in the consolidated balance sheets in accordance with the asset or liability to which they relate or, when applicable, based on the expected timing of the reversals of existing temporary differences. Current deferred tax assets at December 31, 2014 were $20.2 million. The Company has elected early adoption prospectively of ASU 2015-17, as permitted, as of December 31, 2015. Thus, there were no current deferred tax assets at December 31, 2015. Non-current deferred tax assets at December 31, 2015 and 2014 were $49.1 and $13.1 million, respectively. Non-current deferred tax liabilities at December 31, 2015 and 2014 were $23.9 million and $63.9 million, respectively.

The Company records a valuation allowance to reduce its net deferred tax assets to the amount that is more likely than not to be realized. As of December 31, 2015 and 2014, the Company carried a valuation allowance against deferred tax assets of $16.6 million and $4.7 million, respectively.

The domestic net operating loss carryforwards the company has acquired for federal net operating loss carryforwards are approximately $88.0 million as of December 31, 2015. The foreign net operating loss carryforwards as of December 31, 2015 and 2014 are approximately $14.7 million and $23.7 million, respectively, and have no expiration. In addition, the Company has certain foreign tax credits which do not have an expiration date.

The Company has state net operating loss carryfowards at December 31, 2015 and 2014 of approximately $213.9 million and $7.1 million, respectively. These net operating loss carryforwards, if not used to offset future taxable income, will expire from 2031 to 2033. In addition, the Company has certain state tax credits which will begin to expire in 2026 if not utilized.

Income taxes receivable was $6.5 million and $3.4 million at December 31, 2015 and 2014, respectively, and was included in other current assets in the consolidated balance sheet. Income taxes payable of $7.4 and $0.1 million at December 31, 2015 and 2014 was included in other accrued liabilities in the consolidated balance sheet. In addition, income taxes payable of $5.4 million and $2.4 million at December 31, 2015 and 2014, respectively, were included in other liabilities in the consolidated balance sheet. The balance in other liabilities relates to certain unrecognized tax benefits.

A reconciliation of the beginning and ending amount of unrecognized income tax benefits is as follows (in thousands):

	2015	2014	2013
Balance at January 1	$ 2,923	$1,893	$1,195
Additions based on tax positions related to the current year	1,516	—	321
Additions for tax positions of prior years	2,874	1,030	377
Reductions as a result of the lapse of applicable statutes of limitations	(2,802)	—	—
Balance at December 31	$ 4,511	$2,923	$1,893

The Company's continuing accounting policy is to recognize interest and penalties related to income tax matters as a component of tax expense in the consolidated statements of income. The Company recognized interest and penalties relative to uncertain tax positions of $0.3 million, $0.3 million and $0.1 million for the period ending December 31, 2015, 2014 and 2013, respectively. It is possible the amount of unrecognized tax benefit could change in the next twelve months as a result of a lapse of the statute of limitations and settlements with taxing authorities; however, management does not anticipate the change will have a material impact on the Company's consolidated financial statements.

The Company's uncertain tax positions are related to tax years that remain subject to examination by the relevant taxing authorities. The Company and its subsidiaries file income tax returns in federal and in many state and local jurisdictions as well as foreign jurisdictions. The Company is currently under examination by the Internal Revenue Service ("IRS") for the calendar year 2013. The Company may be subject to examination by IRS for calendar year 2012 through 2015. Additionally, any net operating losses that were generated in prior years and utilized in these years may also be subject to examination by the IRS. In foreign jurisdictions, the Company may be subject to examination for calendar years 2011 through 2015. Generally, for state tax purposes, the Company's 2011 through 2015 tax years remain open for examination by the tax authorities. At the date of this report there were no audits or inquires that had progressed sufficiently to predict their ultimate outcome.

One of the Company's Puerto Rico subsidiaries was granted a tax exemption for which a tax credit of up to 15% of eligible payroll expenses is available to offset up to 50% of the income taxes attributed to that entity. The tax exemption will expire on December 31, 2017.

The Company does not provide for U.S. income taxes on the undistributed earnings of its foreign subsidiaries as it is the Company's intention to utilize those earnings in the foreign operations for an indefinite period of time. At December 31, 2015, undistributed earnings of the foreign subsidiaries amounted to approximately $48.0 million. The amount of unrecognized deferred tax liability related to these temporary differences is not practicable at this time as this could be significantly impacted by the source location and amount of the distribution, the underlying tax rate already paid on the earnings, foreign withholding taxes, foreign currency translation adjustment and the opportunity to use foreign tax credits.

11. Derivatives

The Company entered into foreign currency forward contracts during years ended December 31, 2015 and 2014 in connection with acquisitions in the United Kingdom. The foreign currency forward contracts limited the economic risk of changes in the foreign exchange rate between USD and GBP associated with the payment of the purchase price in GBP. These foreign currency forward contracts did not meet the hedge accounting criteria under Accounting Standards Codification 815, *Derivatives and Hedging*. As such, losses (gains) associated with changes in fair value of $1.9 million and $(15.3) million for the years ended December 31, 2015 and 2014, respectively, have been recorded in the consolidated statements of income based on final settlements of these contracts.

12. Fair Value Measurements

The carrying amounts reported for cash and cash equivalents, accounts receivable, other current assets, accounts payable and other current liabilities approximate fair value because of the short-term maturity of these instruments.

The carrying amounts and fair values of the Company's Amended and Restated Senior Credit Facility, 12.875% Senior Notes, 6.125% Senior Notes, 5.125% Senior Notes, 5.625% Senior Notes, 9.0% and 9.5% Revenue Bonds and contingent consideration liability as of December 31, 2015 and 2014 were as follows (in thousands):

	Carrying Amount December 31,		Fair Value December 31,	
	2015	2014	2015	2014
Amended and Restated Senior Credit Facility	$977,861	$525,576	$977,861	$525,576
12.875% Senior Notes due 2018	$ —	$ 96,420	$ —	$109,688
6.125% Senior Notes due 2021	$147,082	$150,000	$149,288	$153,000
5.125% Senior Notes due 2022	$294,749	$300,000	$275,590	$295,500
5.625% Senior Notes due 2023	$639,431	$ —	$604,262	$ —
9.0% and 9.5% Revenue Bonds	$ 23,621	$ 24,274	$ 23,621	$ 24,274
Contingent consideration liabilities	$ 667	$ 3,000	$ 667	$ 3,000

The Company's Amended and Restated Senior Credit Facility, 12.875% Senior Notes, 6.125% Senior Notes, 5.125% Senior Notes, 5.625% Senior Notes and 9.0% and 9.5% Revenue Bonds were categorized as Level 2 in the GAAP fair value hierarchy. Fair values were based on trading activity among the Company's lenders and the average bid and ask price as determined using published rates.

The fair value of the contingent consideration liabilities were categorized as Level 3 in the GAAP fair value hierarchy. The contingent consideration liabilities were valued using a probability-weighted discounted cash flow method. This analysis reflected the contractual terms of the purchase agreements and utilized assumptions with regard to future earnings, probabilities of achieving such future earnings and a discount rate.

13. Leases

The Company is obligated under certain operating leases to rent space for its facilities and other office space. The original terms of the leases typically range from five to ten years, with optional renewal periods.

Aggregate minimum lease payments under non-cancelable operating leases with original or remaining lease terms in excess of one year were as follows as of December 31, 2015 (in thousands):

2016	$ 29,229
2017	23,675
2018	18,513
2019	14,220
2020	11,047
Thereafter	56,522
Total minimum rental obligations	$153,206

During the years ended December 31, 2015, 2014 and 2013, rent expense was $32.5 million, $12.2 million and $10.0 million, respectively.

14. Commitments and Contingencies

The Company is, from time to time, subject to various claims and legal actions that arise in the ordinary course of the Company's business, including claims for damages for personal injuries, medical malpractice, breach of contract, tort and employment related claims. In these actions, plaintiffs request a variety of damages, including, in some instances, punitive and other types of damages that may not be covered by insurance. In the opinion of management, the Company is not currently a party to any proceeding that would individually or in the aggregate have a material adverse effect on the Company's business, financial condition or results of operations.

15. Segment Information

The Company operates in one line of business, which is operating acute inpatient psychiatric facilities, specialty treatment facilities, residential treatment centers and facilities providing outpatient behavioral healthcare services. As management reviews the operating results of its facilities in the United States (the "U.S. Facilities") and its facilities in the United Kingdom (the "U.K. Facilities") separately to assess performance and make decisions, the Company's operating segments include its U.S. Facilities and U.K. Facilities. At December 31, 2015, the U.S. Facilities included 204 behavioral healthcare facilities with approximately 7,700 beds in 39 states and Puerto Rico, and the U.K. Facilities included 54 behavioral healthcare facilities with approximately 2,200 beds in the United Kingdom.

The following tables set forth the financial information by operating segment, including a reconciliation of Segment EBITDA to income from continuing operations before income taxes (in thousands):

	Year Ended December 31,		
	2015	2014	2013
Revenue:			
U.S. Facilities	$1,426,205	$ 850,625	$710,695
U.K. Facilities	360,698	151,127	—
Corporate and Other	7,589	2,849	2,713
	$1,794,492	$1,004,601	$713,408
Segment EBITDA (1):			
U.S. Facilities	$ 377,587	$ 209,668	$172,625
U.K. Facilities	90,035	39,832	—
Corporate and Other	(62,790)	(34,012)	(27,291)
	$ 404,832	$ 215,488	$145,334

	Year Ended December 31,		
	2015	2014	2013
Segment EBITDA (1)	$ 404,832	$215,488	$145,334
Plus (less):			
Equity-based compensation expense	(20,472)	(10,058)	(5,249)
(Loss) gain on foreign currency derivatives	(1,926)	15,262	—
Debt extinguishment costs	(10,818)	—	(9,350)
Transaction-related expenses	(36,571)	(13,650)	(7,150)
Interest expense, net	(106,742)	(48,221)	(37,250)
Depreciation and amortization	(63,550)	(32,667)	(17,090)
Income from continuing operations before income taxes	$ 164,753	$126,154	$ 69,245

	U.S. Facilities	U.K. Facilities	Corporate and Other	Consolidated
Goodwill:				
Balance at January 1, 2015	$ 693,945	$ 109,041	$ —	$ 802,986
Increase from 2015 acquisitions	1,247,647	108,554	—	1,356,201
Foreign currency translation loss	—	(3,848)	—	(3,848)
Other	281	(27,405)	—	(27,124)
Balance at December 31, 2015	$ 1,941,873	$ 186,342	$ —	$2,128,215

	December 31,	
	2015	2014
Assets (2):		
U.S. Facilities	$3,061,519	$1,327,563
U.K. Facilities	1,045,922	726,693
Corporate and Other	171,767	152,699
	$4,279,208	$2,206,955

(1) Segment EBITDA is defined as income from continuing operations before provision for income taxes, equity-based compensation expense, debt extinguishment costs, gain on foreign currency derivatives, transaction-related expenses, interest expense and depreciation and amortization. The Company uses Segment EBITDA as an analytical indicator to measure the performance of the Company's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA is commonly used as an analytical indicator within the health care industry, and also serves as a measure of leverage capacity and debt service ability. Segment EBITDA should not be considered as a measure of financial performance under generally accepted accounting principles, and the items excluded from Segment EBITDA are significant components in understanding and assessing financial performance. Because Segment EBITDA is not a measurement determined in accordance with generally accepted accounting principles and is thus susceptible to varying calculations, Segment EBITDA, as presented, may not be comparable to other similarly titled measures of other companies.

(2) Assets include property and equipment for the U.S. Facilities of $832.2 million, U.K. Facilities of $824.4 million and corporate and other of $52.4 million at December 31, 2015. Assets include property and equipment for the U.S. Facilities of $478.1 million, U.K. Facilities of $578.6 million and corporate and other of $13.0 million at December 31, 2014.

16. Employee Benefit Plans

Defined Contribution Plan

The Company maintains a qualified defined contribution 401(k) plan covering substantially all of its employees in the United States. The Company may, at its discretion, make contributions to the plan. For the years ended December 31, 2015, 2014 and 2013, the Company contributed $0.1 million, $0.1 million and $0.3 million, respectively, to the 401(k) plan.

Partnerships in Care Pension Plan

As part of the acquisition of Partnerships in Care on July 1, 2014, the Company assumed a frozen contributory defined benefit retirement plan ("Partnerships in Care Pension Plan") covering substantially all of the employees of Partnerships in Care and its subsidiaries prior to May 1, 2005 at which time, the Partnerships in Care Plan was frozen to new participants. Effective May 2015, the active participants no longer accrue benefits. The benefits under the Partnerships in Care Pension Plan were primarily based on years of service and final average earnings.

The Company accounts for the Partnerships in Care Pension Plan in accordance with ASC 715-30 "Compensation — Defined Benefit Plans", ("ASC 715-30"). In accordance with ASC 715-30, the Company recognizes the unfunded liability of the Partnerships in Care Pension Plan on the Company's consolidated balance sheet and unrecognized gains (losses) and prior service credits (costs) as changes in other comprehensive income (loss). The measurement date of the Partnerships in Care Pension Plan's assets and liabilities coincides with the Company's year-end. The Company's pension benefit obligation is measured using actuarial calculations that incorporate discount rates, rate of compensation increases, when applicable, expected long-term returns on plan assets and consider expected age of retirement and mortality. Expected return on plan assets is determined by using the specific asset distribution at the measurement date.

The following table summarizes the funded status (unfunded liability) of the Partnerships in Care Pension Plan based upon actuarial valuations prepared as of December 31, 2015 and 2014 (in thousands):

	2015	2014
Projected benefit obligation	$58,107	$66,910
Fair value of plan assets	55,286	57,356
Funded status (unfunded liability)	$ 2,821	$ 9,554

The following table summarizes changes in the Partnerships in Care Pension Plan net pension liability as of December 31, 2015 and 2014 (in thousands):

	2015	2014
Net pension liability at beginning of period	$ 9,554	$7,602
Employer contributions	(1,217)	(825)
Net pension (benefit) expense	(419)	729
Pension liability adjustment	(4,661)	2,758
Foreign currency translation loss	(436)	(710)
Net pension liability at end of period	$ 2,821	$9,554

A pension liability of $2.8 million and $9.6 million were recorded within other liabilities on the consolidated balance sheet as of December 31, 2015 and 2014. The following assumptions were used to determine the plan benefit obligation:

Discount rate	3.8%	3.6%
Compensation increase rate	—%	3.4%
Measurement date	December 31, 2015	December 31, 2014

A summary of the components of net pension plan expense for the year ended December 31, 2015 and the six months ended December 31, 2014 is as follows (in thousands):

	2015	2014
Interest cost on projected benefit obligation	$ 2,369	$ 1,389
Service cost on projected benefit obligation	(616)	545
Curtailments on projected benefit obligation	(1,373)	—
Expected return on assets	(2,031)	(1,205)
Total pension plan (benefit) expense	$ (419)	$ 729

Assumptions used to determine the net periodic pension plan expense for the year ended December 31, 2015 and the six months ended December 31, 2014 were as follows:

	2015	2014
Discount rate	3.8%	3.6%
Expected long-term rate of return on plan assets	3.8%	4.3%

The Company recognizes changes in the funded status of the pension plan as a direct increase or decrease to stockholders' equity through accumulated other comprehensive income. The accumulated other comprehensive income (loss) related to the Partnerships in Care Pension Plan for the years ended December 31, 2015 and 2014 was $2.6 million ($1.7 million net of taxes) and $(2.8) million ($2.2 million net of taxes).

The trustees of the Partnerships in Care Pension Plan are required to invest assets in the best interest of the Partnerships in Care Pension Plan's members and also ensure liquid assets are available to make benefit payments as they become due. Performance of the Partnerships in Care Pension Plan's assets are monitored quarterly, at a minimum, and asset allocations are adjusted as needed. The Partnerships in Care Pension Plan's weighted-average asset allocations by asset category as of December 31, 2015 and 2014 were as follows:

	December 31, 2015	December 31, 2014
Cash and cash equivalents	1.7%	1.3%
United Kingdom government obligation	3.8%	16.1%
Annuity contracts	46.5%	—%
Equity securities	35.7%	43.6%
Debt securities	8.5%	34.1%
Other	3.8%	4.9%

As of December 31, 2015 and 2014, the Partnerships in Care Pension Plan cash and cash equivalents were classified as Level 1 in the GAAP fair value hierarchy. Fair values were based on utilizing quoted prices (unadjusted) in active markets for identical assets. The United Kingdom government obligations, annuity contracts, equity securities, debt securities and other investments were classified as Level 2 in the GAAP fair value hierarchy. Fair values were based on data points that are observable, such as quoted prices, interest rates and yield curves.

Table of Contents

17. Quarterly Information (Unaudited)

The tables below present summarized unaudited quarterly results of operations for the years ended December 31, 2015 and 2014. Management believes that all necessary adjustments have been included in the amounts stated below for a fair presentation of the results of operations for the periods presented when read in conjunction with the Company's consolidated financial statements for the years ended December 31, 2015 and 2014. Results of operations for a particular quarter are not necessarily indicative of results of operations for an annual period and are not predictive of future periods.

	Quarter Ended			
	March 31,	June 30,	September 30,	December 31,
	(In thousands except per share amounts)			
2015:				
Revenue	$365,783	$453,660	$ 479,730	$ 495,319
Income from continuing operations before income taxes	$ 21,205	$ 49,355	$ 41,645(1)	$ 52,518
Net income attributable to Acadia Healthcare Company, Inc. stockholders	$ 14,594	$ 33,844	$ 29,550(1)	$ 34,566
Basic earnings per share attributable to Acadia Healthcare Company, Inc. stockholders	$ 0.23	$ 0.50	$ 0.42(1)	$ 0.49
Diluted earnings per share attributable to Acadia Healthcare Company, Inc. stockholders	$ 0.23	$ 0.49	$ 0.42(1)	$ 0.49
2014:				
Revenue	$201,418	$213,803	$ 294,479	$ 294,901
Income from continuing operations before income taxes	$ 20,796	$ 37,362(2)	$ 33,156(2)	$ 34,840
Net income attributable to Acadia Healthcare Company, Inc. stockholders	$ 13,058	$ 22,451(2)	$ 25,402(2)	$ 22,129
Basic earnings per share attributable to Acadia Healthcare Company, Inc. stockholders	$ 0.26	$ 0.43(2)	$ 0.43(2)	$ 0.38
Diluted earnings per share attributable to Acadia Healthcare Company, Inc. stockholders	$ 0.26	$ 0.43(2)	$ 0.43(2)	$ 0.37

(1) Includes debt extinguishment costs of $10.0 million, or $6.8 million net of taxes, in connection with the redemption of $88.3 million of the 12.875% Senior Notes on September 21, 2015. On November 1, 2015, the Company redeemed all of the outstanding $9.2 million principal amount of the 12.875% Senior Notes and incurred additional debt extinguishment cost of $0.8 million.

(2) Includes gain on foreign currency derivatives of $13.7 million and $1.5 million, in connection with the Partnerships in Care acquisition, for the three months ended June 30, 2014 and September 30, 2014, respectively.

18. Subsequent Events

On February 16, 2016, the Company completed its acquisition of Priory for a total purchase price of approximately $2.2 billion, including total cash consideration of approximately $1.9 billion and the issuance of 4,033,561 shares of its common stock. Priory is the leading independent provider of behavioral healthcare services in the United Kingdom. At December 31, 2015, Priory operated 327 facilities with approximately 7,100 beds. The cash sources included the net proceeds of $685.0 million from a public equity offering of 11,500,000 shares completed on January 12, 2016, $390.0 million from the Company's offering of 6.500% Senior Notes and borrowings of $955.0 million under the New TLB Facility. In addition, the Company used borrowings from its TLA Facility, which was increased by $135.0 million, to pay down the majority of its $300.0 million revolving credit facility. See Note 4 – Acquisitions and Note 7 – Long-Term Debt for additional details.

19. Financial Information for the Company and Its Subsidiaries

The Company conducts substantially all of its business through its subsidiaries. The 12.875% Senior Notes, 6.125% Senior Notes, 5.125% Senior Notes and 5.625% Senior Notes are jointly and severally guaranteed on an unsecured senior basis by all of the Company's subsidiaries that guarantee the Company's obligations under the Amended and Restated Senior Credit Facility. Presented below is condensed consolidating financial information for the Company and its subsidiaries as of December 31, 2015 and 2014, and for the years ended December 31, 2015, 2014 and 2013. The information segregates the parent company (Acadia Healthcare Company, Inc.), the combined wholly-owned subsidiary guarantors, the combined non-guarantor subsidiaries and eliminations.

Table of Contents

Acadia Healthcare Company, Inc.
Condensed Consolidating Balance Sheets
December 31, 2015
(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Current assets:					
Cash and cash equivalents	$ —	$ 1,987	$ 9,228	$ —	$ 11,215
Accounts receivable, net	—	187,546	29,080	—	216,626
Deferred tax assets	—	—	—	—	—
Other current assets	—	57,968	8,927	—	66,895
Total current assets	—	247,501	47,235	—	294,736
Property and equipment, net	—	805,439	903,614	—	1,709,053
Goodwill	—	1,835,339	292,876	—	2,128,215
Intangible assets, net	—	57,024	2,551	—	59,575
Deferred tax assets – noncurrent	3,946	40,587	4,581	—	49,114
Investment in subsidiaries	1,323,069	—	—	(1,323,069)	—
Other assets	427,270	32,947	2,322	(424,024)	38,515
Total assets	$1,754,285	$3,018,837	$1,253,179	$(1,747,093)	$4,279,208
Current liabilities:					
Current portion of long-term debt	$ 45,125	$ —	$ 235	$ —	$ 45,360
Accounts payable	—	75,015	16,326	—	91,341
Accrued salaries and benefits	—	66,249	14,447	—	80,696
Other accrued liabilities	26,132	10,886	35,788	—	72,806
Total current liabilities	71,257	152,150	66,796	—	290,203
Long-term debt	—	2,171,998	447,410	(424,024)	2,195,384
Deferred tax liabilities – noncurrent	—	—	23,936	—	23,936
Other liabilities	—	75,159	3,443	—	78,602
Total liabilities	71,257	2,399,307	541,585	—	2,588,125
Redeemable noncontrolling interests	—	—	8,055	—	8,055
Total equity	1,683,028	619,530	703,539	(1,323,069)	1,683,028
Total liabilities and equity	$1,754,285	$3,018,837	$1,253,179	$(1,747,093)	$4,279,208

Acadia Healthcare Company, Inc.
Condensed Consolidating Balance Sheets
December 31, 2014
(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Current assets:					
Cash and cash equivalents	$ —	$ 76,685	$ 17,355	$ —	$ 94,040
Accounts receivable, net	—	100,797	17,581	—	118,378
Deferred tax assets	—	18,395	1,760	—	20,155
Other current assets	—	36,049	5,521	—	41,570
Total current assets	—	231,926	42,217	—	274,143
Property and equipment, net	—	451,943	617,757	—	1,069,700
Goodwill	—	596,611	206,375	—	802,986
Intangible assets, net	—	19,057	2,579	—	21,636
Deferred tax assets – noncurrent	4,563	—	14,244	(5,666)	13,141
Investment in subsidiaries	1,759,337	—	—	(1,759,337)	—
Other assets	186,073	18,727	2,323	(181,774)	25,349
Total assets	$1,949,973	$1,318,264	$ 885,495	$(1,946,777)	$2,206,955
Current liabilities:					
Current portion of long-term debt	$ 26,750	$ —	$ 215	$ —	$ 26,965
Accounts payable	—	39,486	9,210	—	48,696
Accrued salaries and benefits	—	47,597	11,720	—	59,317
Other accrued liabilities	13,647	7,688	9,621	—	30,956
Total current liabilities	40,397	94,771	30,766	—	165,934
Long-term debt	1,028,611	—	205,833	(181,774)	1,052,670
Deferred tax liabilities – noncurrent	—	21,027	48,519	(5,666)	63,880
Other liabilities	—	33,321	10,185	—	43,506
Total liabilities	1,069,008	149,119	295,303	(187,440)	1,325,990
Total equity	880,965	1,169,145	590,192	(1,759,337)	880,965
Total liabilities and equity	$1,949,973	$1,318,264	$ 885,495	$(1,946,777)	$2,206,955

Acadia Healthcare Company, Inc.
Condensed Consolidating Statement of Comprehensive Income
Year Ended December 31, 2015
(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Revenue before provision for doubtful accounts	$ —	$1,415,016	$ 414,603	$ —	$1,829,619
Provision for doubtful accounts	—	(32,614)	(2,513)	—	(35,127)
Revenue	—	1,382,402	412,090	—	1,794,492
Salaries, wages and benefits	20,472	726,215	227,045	—	973,732
Professional fees	—	83,422	33,041	—	116,463
Supplies	—	65,077	15,586	—	80,663
Rents and leases	—	29,094	3,434	—	32,528
Other operating expenses	—	170,018	36,728	—	206,746
Depreciation and amortization	—	41,768	21,782	—	63,550
Interest expense, net	68,533	17,476	20,733	—	106,742
Debt extinguishment costs	10,818	—	—	—	10,818
Loss on foreign currency derivatives	1,926	—	—	—	1,926
Transaction-related expenses	—	24,914	11,657	—	36,571
Total expenses	101,749	1,157,984	370,006	—	1,629,739
(Loss) income from continuing operations before income taxes	(101,749)	224,418	42,084	—	164,753
Equity in earnings of subsidiaries	176,178	—	—	(176,178)	—
(Benefit from) provision for income taxes	(37,047)	85,765	4,670	—	53,388
Income (loss) from continuing operations	111,476	138,653	37,414	(176,178)	111,365
Income from discontinued operations, net of income taxes	—	111	—	—	111
Net income (loss)	111,476	138,764	37,414	(176,178)	111,476
Net loss attributable to noncontrolling interests	—	—	1,078	—	1,078
Net income attributable to Acadia Healthcare Company, Inc.	$ 111,476	$ 138,764	$ 38,492	$ (176,178)	$ 112,554
Other comprehensive income:					
Foreign currency translation gain	—	—	(40,103)	—	(40,103)
Pension liability adjustment, net	—	—	3,826	—	3,826
Other comprehensive income	—	—	(36,277)	—	(36,277)
Comprehensive income (loss)	$ 111,476	$ 138,764	$ 2,215	$ (176,178)	$ 76,277

Acadia Healthcare Company, Inc.
Condensed Consolidating Statement of Comprehensive Income
Year Ended December 31, 2014
(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Revenue before provision for doubtful accounts	$ —	$ 826,465	$ 204,319	$ —	$1,030,784
Provision for doubtful accounts	—	(23,866)	(2,317)	—	(26,183)
Revenue	—	802,599	202,002	—	1,004,601
Salaries, wages and benefits	10,058	459,297	106,057	—	575,412
Professional fees	—	38,632	13,850	—	52,482
Supplies	—	40,511	7,911	—	48,422
Rents and leases	—	10,136	2,065	—	12,201
Other operating expenses	—	83,835	26,819	—	110,654
Depreciation and amortization	—	22,990	9,677	—	32,667
Interest expense, net	27,199	6,207	14,815	—	48,221
Gain on foreign currency derivatives	(15,262)	—	—	—	(15,262)
Transaction-related expenses	—	12,367	1,283	—	13,650
Total expenses	21,995	673,975	182,477	—	878,447
(Loss) income from continuing operations before income taxes	(21,995)	128,624	19,525	—	126,154
Equity in earnings of subsidiaries	97,414	—	—	(97,414)	—
(Benefit from) provision for income taxes	(7,621)	44,608	5,935	—	42,922
Income (loss) from continuing operations	83,040	84,016	13,590	(97,414)	83,232
Loss from discontinued operations, net of income taxes	—	(192)	—	—	(192)
Net income (loss)	$ 83,040	$ 83,824	$ 13,590	$ (97,414)	$ 83,040
Other comprehensive loss:					
Foreign currency translation loss	—	—	(66,206)	—	(66,206)
Pension liability adjustment, net	—	—	(2,164)	—	(2,164)
Other comprehensive loss	—	—	(68,370)	—	(68,370)
Comprehensive income (loss)	$ 83,040	$ 83,824	$ (54,780)	$ (97,414)	$ 14,670

Table of Contents

Acadia Healthcare Company, Inc.
Condensed Consolidating Statement of Comprehensive Income
Year Ended December 31, 2013
(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Revenue before provision for doubtful accounts	$ —	$ 700,407	$ 34,702	$ —	$ 735,109
Provision for doubtful accounts	—	(20,700)	(1,001)	—	(21,701)
Revenue	—	679,707	33,701	—	713,408
Salaries, wages and benefits	5,249	388,749	13,964	—	407,962
Professional fees	—	34,149	3,022	—	37,171
Supplies	—	35,686	1,883	—	37,569
Rents and leases	—	9,282	767	—	10,049
Other operating expenses	—	72,626	7,946	—	80,572
Depreciation and amortization	—	15,882	1,208	—	17,090
Interest expense, net	35,327	22	1,901	—	37,250
Debt extinguishment costs	9,350	—	—	—	9,350
Transaction-related expenses	—	6,716	434	—	7,150
Total expenses	49,926	563,112	31,125	—	644,163
(Loss) income from continuing operations before income taxes	(49,926)	116,595	2,576	—	69,245
Equity in earnings of subsidiaries	73,538	—	—	(73,538)	—
(Benefit from) provision for income taxes	(18,967)	44,294	648	—	25,975
Income (loss) from continuing operations	42,579	72,301	1,928	(73,538)	43,270
Loss from discontinued operations, net of income taxes	—	(691)	—	—	(691)
Net income (loss)	$ 42,579	$ 71,610	$ 1,928	$ (73,538)	$ 42,579
Comprehensive income (loss)	$ 42,579	$ 71,610	$ 1,928	$ (73,538)	$ 42,579

SUPPLEMENTAL #1

March 28, 2016

11:49 am

Table of Contents

Acadia Healthcare Company, Inc.
Condensed Consolidating Statement of Cash Flows
Year Ended December 31, 2015
(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Operating activities:					
Net income (loss)	$ 111,476	$ 138,764	$ 37,414	$ (176,178)	$ 111,476
Adjustments to reconcile net income (loss) to net cash (used in) provided by continuing operating activities:					
Equity in earnings of subsidiaries	(176,178)	—	—	176,178	—
Depreciation and amortization	—	41,768	21,782	—	63,550
Amortization of debt issuance costs	7,147	—	(438)	—	6,709
Equity-based compensation expense	20,472	—	—	—	20,472
Deferred income tax (benefit) expense	617	42,246	750	—	43,613
Loss from discontinued operations, net of taxes	—	(111)	—	—	(111)
Debt extinguishment costs	10,818	—	—	—	10,818
Loss (gain) on foreign currency derivatives	1,926	—	—	—	1,926
Other	—	1,582	33	—	1,615
Change in operating assets and liabilities, net of effect of acquisitions:					
Accounts receivable, net	—	(18,632)	(6,322)	—	(24,954)
Other current assets	—	(1,152)	(1,565)	—	(2,717)
Other assets	(1,100)	(8,567)	546	1,100	(8,021)
Accounts payable and other accrued liabilities	—	(7,583)	14,451	—	6,868
Accrued salaries and benefits	—	312	1,346	—	1,658
Other liabilities	—	9,350	(114)	—	9,236
Net cash (used in) provided by continuing operating activities	(24,822)	197,977	67,883	1,100	242,138
Net cash provided by discontinued operating activities	—	(1,735)	—	—	(1,735)
Net cash (used in) provided by operating activities	(24,822)	196,242	67,883	1,100	240,403
Investing activities:					
Cash paid for acquisitions, net of cash acquired	—	(254,848)	(319,929)	—	(574,777)
Cash paid for capital expenditures	—	(172,329)	(103,718)	—	(276,047)
Cash paid for real estate acquisitions	—	(25,293)	(1,329)	—	(26,622)
Settlement of foreign currency derivatives	—	(1,926)	—	—	(1,926)
Other	—	(5,099)	—	—	(5,099)
Net cash used in investing activities	—	(459,495)	(424,976)	—	(884,471)
Financing activities:					
Borrowings on long-term debt	1,150,000	—	—	—	1,150,000
Borrowings on revolving credit facility	468,000	—	—	—	468,000
Principal payments on revolving credit facility	(310,000)	—	—	—	(310,000)
Principal payments on long-term debt	(31,965)	—	(1,315)	1,315	(31,965)
Repayment of assumed CRC debt	(904,467)	—	—	—	(904,467)
Repayments of senior notes	(97,500)	—	—	—	(97,500)
Payment of debt issuance costs	(26,421)	—	—	—	(26,421)
Payment of premium on senior notes	(7,480)	—	—	—	(7,480)
Issuance of Common Stock	—	331,308	—	—	331,308
Common stock withheld for minimum statutory taxes, net	(7,762)	—	—	—	(7,762)
Excess tax benefit from equity awards	309	—	—	—	309
Other	—	(420)	—	—	(420)
Cash provided by (used in) intercompany activity	(207,892)	(139,974)	350,281	(2,415)	—
Net cash provided by (used in) financing activities	24,822	190,914	348,966	(1,100)	563,602
Effect of exchange rate changes on cash	—	(2,359)	—	—	(2,359)
Net (decrease) increase in cash and cash equivalents	—	(74,698)	(8,217)	—	(82,825)
Cash and cash equivalents at beginning of the period	—	76,685	17,355	—	94,040
Cash and cash equivalents at end of the period	$ —	$ 1,987	$ 9,228	$ —	$ 11,215

Acadia Healthcare Company, Inc.
Condensed Consolidating Statement of Cash Flows
Year Ended December 31, 2014
(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Operating activities:					
Net income (loss)	$ 83,040	$ 83,824	$ 13,590	$ (97,414)	$ 83,040
Adjustments to reconcile net income (loss) to net cash (used in) provided by continuing operating activities:					
Equity in earnings of subsidiaries	(97,414)	—	—	97,414	—
Depreciation and amortization	—	22,990	9,677	—	32,667
Amortization of debt issuance costs	2,748	—	450	—	3,198
Equity-based compensation expense	10,058	—	—	—	10,058
Deferred income tax (benefit) expense	(1,969)	5,231	3,953	—	7,215
Loss from discontinued operations, net of taxes	—	192	—	—	192
Gain on foreign currency derivatives	(15,262)	—	—	—	(15,262)
Other	—	449	39	—	488
Change in operating assets and liabilities, net of effect of acquisitions:					
Accounts receivable, net	—	(13,636)	(1,474)	—	(15,110)
Other current assets	—	(2,205)	194	—	(2,011)
Other assets	(1,151)	(6,910)	397	1,151	(6,513)
Accounts payable and other accrued liabilities	—	(5,559)	8,352	—	2,793
Accrued salaries and benefits	—	11,035	945	—	11,980
Other liabilities	—	1,769	980	—	2,749
Net cash (used in) provided by continuing operating activities	(19,950)	97,180	37,103	1,151	115,484
Net cash used in discontinued operating activities	—	(198)	—	—	(198)
Net cash (used in) provided by operating activities	(19,950)	96,982	37,103	1,151	115,286
Investing activities:					
Cash paid for acquisitions, net of cash acquired	—	(723,064)	(15,638)	—	(738,702)
Cash paid for capital expenditures	—	(83,864)	(29,380)	—	(113,244)
Cash paid for real estate acquisitions	—	(23,177)	—	—	(23,177)
Settlement of foreign currency derivatives	15,262	—	—	—	15,262
Other	—	(913)	—	—	(913)
Net cash used in investing activities	15,262	(831,018)	(45,018)	—	(860,774)
Financing activities:					
Borrowings on long-term debt	542,500	—	—	—	542,500
Borrowings on revolving credit facility	230,500	—	—	—	230,500
Principal payments on revolving credit facility	(284,000)	—	—	—	(284,000)
Principal payments on long-term debt	(7,500)	—	(1,346)	1,151	(7,695)
Payment of debt issuance costs	(12,993)	—	—	—	(12,993)
Issuance of common stock, net	374,431	—	—	—	374,431
Common stock withheld for minimum statutory taxes, net	(4,099)	—	—	—	(4,099)
Excess tax benefit from equity awards	4,617	—	—	—	4,617
Cash paid for contingent consideration	—	(5,000)	—	—	(5,000)
Other	—	(289)	—	—	(289)
Cash (used in) provided by intercompany activity	(838,768)	816,010	23,135	(377)	—
Net cash provided by financing activities	4,688	810,721	21,789	774	837,972
Effect of exchange rate changes on cash	—	—	(3,013)	—	(3,013)
Net increase in cash and cash equivalents	—	76,685	10,861	1,925	89,471
Cash and cash equivalents at beginning of the period	—	—	6,494	(1,925)	4,569
Cash and cash equivalents at end of the period	$ —	$ 76,685	$ 17,355	$ —	$ 94,040

Table of Contents

Acadia Healthcare Company, Inc.
Condensed Consolidating Statement of Cash Flows
Year Ended December 31, 2013
(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Operating activities:					
Net income (loss)	$ 42,579	$ 71,610	$ 1,928	$ (73,538)	$ 42,579
Adjustments to reconcile net income (loss) to net cash (used in) provided by continuing operating activities:					
Equity in earnings of subsidiaries	(73,538)	—	—	73,538	—
Depreciation and amortization	—	15,882	1,208	—	17,090
Amortization of debt issuance costs	2,725	—	(461)	—	2,264
Equity-based compensation expense	5,249	—	—	—	5,249
Deferred income tax expense	(754)	10,278	559	—	10,083
Loss from discontinued operations, net of taxes	—	691	—	—	691
Debt extinguishment costs	9,350	—	—	—	9,350
Other	—	21	—	—	21
Change in operating assets and liabilities, net of effect of acquisitions:					
Accounts receivable, net	—	(22,768)	1,526	—	(21,242)
Other current assets	—	(3,774)	122	—	(3,652)
Other assets	—	(1,950)	(289)	—	(2,239)
Accounts payable and other accrued liabilities	—	(287)	(561)	—	(848)
Accrued salaries and benefits	—	2,161	642	—	2,803
Other liabilities	—	3,181	—	—	3,181
Net cash (used in) provided by continuing operating activities	(14,389)	75,045	4,674	—	65,330
Net cash used in discontinued operating activities	—	232	—	—	232
Net cash (used in) provided by operating activities	(14,389)	75,277	4,674	—	65,562
Investing activities:					
Cash paid for acquisitions, net of cash acquired	—	(164,019)	—	—	(164,019)
Cash paid for capital expenditures	—	(68,497)	(444)	—	(68,941)
Cash paid for real estate acquisitions	—	(8,092)	—	—	(8,092)
Other	—	(1,926)	—	—	(1,926)
Net cash used in investing activities	—	(242,534)	(444)	—	(242,978)
Financing activities:					
Borrowings on long-term debt	150,000	—	—	—	150,000
Borrowings on revolving credit facility	61,500	—	—	—	61,500
Principal payments on revolving credit facility	(8,000)	—	—	—	(8,000)
Principal payments on long-term debt	(7,500)	—	(180)	—	(7,680)
Repayment of long-term debt	(52,500)	—	—	—	(52,500)
Payment of debt issuance costs	(4,307)	—	—	—	(4,307)
Payment of premium on note redemption	(6,759)	—	—	—	(6,759)
Issuance of common stock, net	(205)	—	—	—	(205)
Common stock withheld for minimum statutory taxes, net	(1,242)	—	—	—	(1,242)
Excess tax benefit from equity awards	1,779	—	—	—	1,779
Cash (used in) provided by intercompany activity	(118,377)	117,950	2,352	(1,925)	—
Net cash (used in) provided by financing activities	14,389	117,950	2,172	(1,925)	132,586
Net (decrease) increase in cash and cash equivalents	—	(49,307)	6,402	(1,925)	(44,830)
Cash and cash equivalents at beginning of the period	—	49,307	92	—	49,399
Cash and cash equivalents at end of the period	$ —	$ —	$ 6,494	$ (1,925)	$ 4,569

SUPPLEMENTAL #1
March 28, 2016
11:49 am

Table of Contents

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Acadia Healthcare Company, Inc.

By: /s/ JOEY A. JACOBS
Joey A. Jacobs
Chairman of the Board and Chief Executive Officer

Dated: February 25, 2016

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ JOEY A. JACOBS Joey A. Jacobs	Chairman of the Board and Chief Executive Officer (Principal Executive Officer)	February 25, 2016
/s/ DAVID M. DUCKWORTH David M. Duckworth	Chief Financial Officer (Principal Financial Officer and Principal Accounting Officer)	February 25, 2016
/s/ BRUCE A. SHEAR Bruce A. Shear	Executive Vice Chairman, Director	February 25, 2016
/s/ E. PEROT BISSELL E. Perot Bissell	Director	February 25, 2016
/s/ CHRISTOPHER R. GORDON Christopher R. Gordon	Director	February 25, 2016
/s/ WILLIAM F. GRIECO William F. Grieco	Director	February 25, 2016
/s/ KYLE D. LATTNER Kyle D. Lattner	Director	February 25, 2016
/s/ WADE D. MIQUELON Wade D. Miquelon	Director	February 25, 2016
/s/ WILLIAM M. PETRIE William M. Petrie	Director	February 25, 2016
/s/ HARTLEY R. ROGERS Hartley R. Rogers	Director	February 25, 2016
/s/ REEVE B. WAUD Reeve B. Waud	Director	February 25, 2016

SUPPLEMENTAL #1
March 28, 2016
11:49 am

Table of Contents

EXHIBIT INDEX

Exhibit No.	Exhibit Description
2.1	Agreement and Plan of Merger, dated May 23, 2011, by and among Acadia Healthcare Company, Inc. (the "Company"), Acadia Merger Sub, LLC and PHC, Inc. (a)
2.2	Agreement and Plan of Merger, dated February 17, 2011, by and among the Company (f/k/a Acadia Healthcare Company, LLC), Acadia—YFCS Acquisition Company, Inc., Acadia—YFCS Holdings, Inc., Youth & Family Centered Services, Inc., each of the stockholders who are signatories thereto, and TA Associates, Inc., solely in the capacity as Stockholders' Representative. (b)
2.3	Asset Purchase Agreement, dated as of March 15, 2011, between Universal Health Services, Inc. and PHC, Inc. for the acquisition of MeadowWood Behavioral Health System. (c)
2.4	Membership Interest Purchase Agreement, dated December 30, 2011, by and among Hermitage Behavioral, LLC, Haven Behavioral Healthcare Holdings, LLC and Haven Behavioral Healthcare, Inc. (d)
2.5	Asset Purchase Agreement, dated August 28, 2012, by and between Timberline Knolls, LLC, and TK Behavioral, LLC. (e)
2.6	Acquisition Agreement, dated November 21, 2012, by and among (i) Behavioral Centers of America, LLC, (ii) Behavioral Centers of America Holdings, LLC, (iii) Linden BCA Blocker Corp., (iv) SBOF-BCA Holdings Corporation, (v) HEP BCA Holdings Corp. (vi) Siguler Guff Small Buyout Opportunities Fund, LP, and Siguler Guff Small Buyout Opportunities Fund (F), LP, (vii) Health Enterprise Partners, L.P., HEP BCA Co-Investors, LLC, (viii) Linden Capital Partners A, LP, (ix) Commodore Acquisition Sub, LLC, and (x) the Company (the "BCA Purchase Agreement"). (f)
2.7	Amendment No. 1, dated as of December 31, 2012, to the BCA Purchase Agreement. (g)
2.8	Membership Interest Purchase Agreement, dated November 23, 2012 by and among 2C4K, L.P., ARTC Acquisitions, Inc., Acadia Vista, LLC and the Company. (f)
2.9	Amendment, dated as of December 31, 2012, to Membership Interest Purchase Agreement by and among 2C4K, LP, ARTC Acquisitions, Inc., Acadia Vista, LLC and the Company. (g)
2.10	Stock Purchase Agreement, dated as of March 29, 2013, by and among First Ten Broeck Tampa, Inc., UMC Ten Broeck, Inc., Capestrano Holding 12, Inc., Donald R. Dizney, David A. Dizney and Acadia Merger Sub, LLC. (h)
2.11	Agreement, dated June 3, 2014, by and among Partnerships in Care Holdings Limited, The Royal Bank of Scotland plc, Piper Holdco 2, Ltd. and the Company. (i)
2.12	Agreement and Plan of Merger, dated as of October 29, 2014, by and among the Company, Copper Acquisition Co., Inc. and CRC Health Group, Inc. (j)
2.13	Sale and Purchase Deed, dated as of December 31, 2015, by and among Whitewell UK Investments 1 Limited, the institutional sellers named therein, Appleby Trust (Jersey) Limited, the management sellers named therein, and the Company. (ii)
2.14	Amendment to Sale the Purchase Deed by and among Whitewell UK Investments 1 Limited, the representative of the institutional sellers named therein, the representative of the management sellers named therein, and the Company. (jj)
3.1	Amended and Restated Certificate of Incorporation, as filed on October 28, 2011 with the Secretary of State of the State of Delaware. (k)
3.2	Amended and Restated Bylaws of the Company. (k)

SUPPLEMENTAL #1
March 28, 2016
11:49 am

Table of Contents

Exhibit No.	Exhibit Description
4.1	Indenture, dated as of March 12, 2013, among the Company, the guarantors named therein and U.S. Bank National Association, as Trustee. (m)
4.2	Form of 6.125% Senior Note due 2021. (Included in Exhibit 4.1)
4.3	Registration Rights Agreement, dated March 12, 2013, among the Company, the guarantors named therein and Merrill Lynch, Pierce, Fenner & Smith Incorporated. (m)
4.4	Indenture, dated July 1, 2014, by and among the Company, the guarantors party thereto and U.S. Bank National Association, as Trustee. (n)
4.5	Supplemental Indenture, dated as of August 4, 2014, to the Indenture, dated as of July 1, 2014, among the Company, the guarantors named therein and U.S. Bank National Association, as Trustee. (o)
4.6	Form of 5.125% Senior Note due 2022 (Included in Exhibit 4.4).
4.7	Registration Rights Agreement, dated July 1, 2014, by and among the Company, the guarantors party thereto and Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC, as Representatives of the Initial Purchasers. (n)
4.8	Indenture, dated February 11, 2015, by and among the Company, the guarantors party thereto and U.S. Bank National Association, as Trustee. (p)
4.9	Form of 5.625% Senior Note due 2023 (Included in Exhibit 4.8).
4.10	Registration Rights Agreement, dated February 11, 2015, by and among the Company, the guarantors party thereto and Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC, as Representatives of the Initial Purchasers. (p)
4.11	Registration Rights Agreement, dated September 21, 2015, by and among the Company, the guarantors party thereto and Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC, as Representatives of the Initial Purchasers. (hh)
4.12	Indenture, dated February 16, 2016, by and among the Company, the guarantors party thereto and Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC, as Representatives of the Initial Purchasers. (mm)
4.13	Form of 6.500% Senior Note due 2024 (Included in Exhibit 4.12).
4.14	Registration Rights Agreement, dated February 16, 2016, by and among the Company, the guarantors party thereto and Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC, as Representatives of the Initial Purchasers. (mm)
4.15	Amended and Restated Stockholders Agreement, dated as of October 29, 2014, by and among the Company and each of the stockholders named therein. (j)
4.16	Specimen Acadia Healthcare Company, Inc. Common Stock Certificate to be issued to holders of Acadia Healthcare Company, Inc. Common Stock. (r)
4.17	Second Amended and Restated Registration Rights Agreement, dated as of October 29, 2014, by and among the Company and each of the parties named therein. (j)
4.18	Amendment, dated February 11, 2015, to the Second Amended and Restated Registration Rights Agreement dated as of October 29, 2014, by and among the Company and each of the parties named therein. (p)
4.19	Third Amended and Restated Registration Rights Agreement, dated as of December 31, 2015, by and among the Company and each of the parties named therein. (ii)

SUPPLEMENTAL #1
March 28, 2016
11:49 am

Table of Contents

Exhibit No.	Exhibit Description
4.20	Form of Subscription Agreement and Warrant. (s)
10.1	Amended and Restated Credit Agreement, dated December 31, 2012, by and among Bank of America, NA (Administrative Agent, Swing Line Lender and L/C Issuer) and the Company (f/k/a Acadia Healthcare Company, LLC), the guarantors listed on the signature pages thereto, and the lenders listed on the signature pages thereto (the "Credit Agreement"). (g)
10.2	First Amendment, dated March 11, 2013, to the Credit Agreement. (m)
10.3	Second Amendment, dated June 28, 2013, to the Credit Agreement. (t)
10.4	Third Amendment, dated September 30, 2013, to the Credit Agreement. (u)
10.5	Fourth Amendment, dated February 13, 2014, to the Credit Agreement. (v)
10.6	Fifth Amendment, dated June 16, 2014, to the Credit Agreement. (w)
10.7	Sixth Amendment, dated December 15, 2014, to the Credit Agreement. (x)
10.8	Seventh Amendment, dated February 6, 2015, to the Credit Agreement. (p)
10.9	First Incremental Facility Amendment, dated February 11, 2015, to the Credit Agreement. (p)
10.10	Eighth Amendment, dated April 22, 2015, to the Credit Agreement. (ff)
10.11	Ninth Amendment, dated January 25, 2016, to the Credit Agreement. (kk)
10.12	Second Incremental Facility Amendment, dated February 16, 2016, to the Credit Agreement. (mm)
†10.13	Amended and Restated Employment Agreement, dated April 7, 2014, among the Company, Acadia Management Company, Inc. and Joey A. Jacobs. (y)
†10.14	Amended and Restated Employment Agreement, dated April 7, 2014, among the Company, Acadia Management Company, Inc. and Brent Turner. (y)
†10.15	Amended and Restated Employment Agreement, dated April 7, 2014, among the Company, Acadia Management Company, Inc. and Ronald M. Fincher. (y)
†10.16	Amended and Restated Employment Agreement, dated April 7, 2014, among the Company, Acadia Management Company, Inc. and Christopher L. Howard. (y)
†10.17	Employment Agreement, dated April 7, 2014, by and among the Company, Acadia Management Company, Inc. and David M. Duckworth. (y)
†10.18	Employment Agreement, dated as of May 23, 2011, by and between the Company and Bruce A. Shear. (b)
†10.19	PHC, Inc.'s 1993 Stock Purchase and Option Plan, as amended December 2002. (z)
†10.20	PHC, Inc.'s 1995 Non-Employee Director Stock Option Plan, as amended December 2002. (z)
†10.21	PHC, Inc.'s 1995 Employee Stock Purchase Plan, as amended December 2002. (z)
†10.22	PHC, Inc.'s 2004 Non-Employee Director Stock Option Plan. (aa)
†10.23	PHC, Inc.'s 2005 Employee Stock Purchase Plan. (bb)
†10.24	PHC, Inc.'s 2003 Stock Purchase and Option Plan, as amended December 2007. (bb)

Exhibit No.	Exhibit Description
†10.25	Acadia Healthcare Company, Inc. Incentive Compensation Plan, effective May 23, 2013. (cc)
†10.26	Form of Restricted Stock Unit Agreement. (b)
†10.27	Form of Incentive Stock Option Agreement. (b)
†10.28	Form of Non-Qualified Stock Option Agreement. (b)
†10.29	Form of Restricted Stock Agreement. (b)
†10.30	Form of Stock Appreciation Rights Agreement. (b)
†10.31	Acadia Healthcare Company, Inc. Nonqualified Deferred Compensation Plan, effective February 1, 2013. (dd)
†10.32	Nonmanagement Director Compensation Program, effective January 1, 2013. (dd)
10.33	Form of Indemnification Agreement (for directors and officers affiliated with Waud Capital Partners or Bain Capital). (k)
10.34	Form of Indemnification Agreement (for directors and officers not affiliated with Waud Capital Partners or Bain Capital). (k)
10.35	Purchase Agreement, dated March 7, 2013, by and among the Company, the guarantors and Merrill Lynch, Pierce, Fenner & Smith Incorporated as representative of the initial purchasers named therein. (m)
10.36	Purchase Agreement, dated June 17, 2014, by and among the Company, the guarantors, Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC as representatives of the initial purchasers named therein. (l)
10.37	Purchase Agreement, dated February 5, 2015, by and among the Company, the guarantors, Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC as representatives of the initial purchasers named therein. (ee)
10.38	Purchase Agreement, dated September 14, 2015, by and among the Company, the guarantors, Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC, as representatives of the initial purchasers named therein. (gg)
10.39	Purchase Agreement, dated February 4, 2016, by and among the Company, the guarantors, Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC as representatives of the initial purchasers named therein. (ll)
21*	Subsidiaries of the Company.
23*	Consent of Independent Registered Public Accounting Firm.
31.1*	Rule 13a-14(a) Certification of the Chief Executive Officer of the Company pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2*	Rule 13a-14(a) Certification of the Chief Financial Officer of the Company pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1*	Section 1350 Certification of Chairman of the Board and Chief Executive Officer of the Company pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2*	Section 1350 Certification of Chief Financial Officer of the Company pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS**	XBRL Instance Document.
101.SCH**	XBRL Taxonomy Extension Schema Document.

SUPPLEMENTAL #1
March 28, 2016
11:49 am

Table of Contents

Exhibit No.	Exhibit Description
101.CAL**	XBRL Taxonomy Calculation Linkbase Document.
101.LAB**	XBRL Taxonomy Labels Linkbase Document.
101.PRE**	XBRL Taxonomy Presentation Linkbase Document.

† Indicates management contract or compensatory plan or arrangement.
* Filed herewith.
** The XBRL related information in Exhibit 101 to this Annual Report on Form 10-K shall not be deemed "filed" for purposes of Section 18 of the Securities Exchange Act of 1934, as amended, or otherwise subject to liability of that section and shall not be incorporated by reference into any filing or other document pursuant to the Securities Act of 1933, as amended, except as shall be expressly set forth by specific reference in such filing or document.
(a) Incorporated by reference to exhibits filed with PHC, Inc.'s Current Report on Form 8-K filed May 25, 2011 (File No. 001-33323).
(b) Incorporated by reference to exhibits filed with the Company's registration statement on Form S-4, as amended (File No. 333-175523), originally filed with the SEC on July 13, 2011.
(c) Incorporated by reference to exhibits filed with PHC, Inc.'s Current Report on Form 8-K filed March 18, 2011 (File No. 001-33323).
(d) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed January 5, 2012 (File No. 001-35331).
(e) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed September 4, 2012 (File No. 001-35331).
(f) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed November 27, 2012 (File No. 001-35331).
(g) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed January 2, 2013 (File No. 001-35331).
(h) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed April 4, 2013 (File No. 001-35331).
(i) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed June 6, 2014 (File No. 001-35331).
(j) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed October 30, 2014 (File No. 001-35331).
(k) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed November 1, 2011 (File No. 001-35331).
(l) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed June 18, 2014 (File No. 001-35331).
(m) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed March 12, 2013 (File No. 001-35331).
(n) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed July 2, 2014 (File No. 001-35331).
(o) Incorporated by reference to exhibits filed with the Company's registration statement on Form S-4 filed August 8, 2014 (File No. 333-198004).
(p) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed February 12, 2015 (File No. 001-35331).
(q) Incorporated by reference to exhibits filed with the Company's Quarterly Report on Form 10-Q for the three months ended June 30, 2012 (File No. 001-35331).
(r) Incorporated by reference to exhibits filed with the Company's registration statement on Form S-1, as amended (File No. 333-175523), originally filed with the SEC on November 23, 2011.
(s) Incorporated by reference to exhibits filed with PHC, Inc.'s Current Report on Form 8-K filed May 13, 2004 (File No. 001-33323).
(t) Incorporated by reference to exhibits filed with the Company's Quarterly Report on Form 10-Q for the three months ended June 30, 2013 (File No. 001-35331).
(u) Incorporated by reference to exhibits filed with the Company's Quarterly Report on Form 10-Q for the three months ended September 30, 2013 (File No. 001-35331).

Table of Contents

(v) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed February 19, 2014 (File No. 001-35331).
(w) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed June 17, 2014 (File No. 001-35331).
(x) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed December 15, 2014 (File No. 001-35331).
(y) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed April 11, 2014 (File No. 001-35331).
(z) Incorporated by reference to exhibits filed with PHC, Inc.'s registration statement on Form S-8 filed January 8, 2003 (File No. 333-102402).
(aa) Incorporated by reference to exhibits filed with PHC, Inc.'s registration statement on Form S-8 filed April 5, 2005 (File No. 333-123842).
(bb) Incorporated by reference to exhibits filed with PHC, Inc.'s registration statement on Form S-8 filed March 6, 2008 (File No. 333-149579).
(cc) Incorporated by reference to exhibits filed with the Company's registration statement on Form S-8 filed July 30, 2013 (File No. 333-190232).
(dd) Incorporated by reference to exhibits filed with the Company's Quarterly Report on Form 10-Q for the three months ended March 31, 2013 (File No. 001-35331).
(ee) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed February 6, 2015 (File No. 001-35331).
(ff) Incorporated by reference to exhibits filed with the Company's Quarterly Report on Form 10-Q for the three months ended March 31, 2015 (File No. 001-35331).
(gg) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed September 15, 2015 (File No. 001-35331).
(hh) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed September 21, 2015 (File No. 001-35331).
(ii) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed January 4, 2016 (File No. 001-35331).
(jj) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed January 8, 2016 (File No. 001-35331).
(kk) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed January 27, 2016 (File No. 001-35331).
(ll) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed February 5, 2016 (File No. 001-35331).
(mm) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed February 16, 2016 (File No. 001-35331).

SUPPLEMENTAL #1

March 28, 2016
11:49 am

Exhibit 21

LIST OF SUBSIDIARIES

Name of Subsidiary *(including dba name, if applicable)*	Jurisdiction / Country of Incorporation or Organization
Abilene Behavioral Health, LLC	Delaware
Abilene Holding Company, LLC	Delaware
Acadia Management Company, LLC	Delaware
Acadia Merger Sub, LLC	Delaware
Acadiana Addiction Center, LLC	Delaware
dba Acadiana Addiction Center	
Advanced Treatment Systems, LLC	Virginia
dba Coatesville Treatment Center	
dba Lebanon Treatment Center	
Affinity Healthcare Holdings Limited	United Kingdom
Affinity Healthcare Limited	United Kingdom
Affinity Hospitals Group Limited	United Kingdom
Affinity Hospitals Holdings Limited	United Kingdom
Affinity Hospitals Limited	United Kingdom
Amore (Ben Madigan) Limited	United Kingdom
Amore (Bourne) Limited	United Kingdom
Amore (Cockermouth) Limited	United Kingdom
Amore (Coventry) Limited	Isle of Man
Amore (Ings Road) Limited	United Kingdom
Amore (Prestwick) Limited	United Kingdom
Amore (Stoke 1) Limited	United Kingdom
Amore (Stoke 2) Limited	United Kingdom
Amore (Warrenpoint) Limited	United Kingdom
Amore (Watton) Limited	United Kingdom
Amore (Wednesfield 1) Limited	United Kingdom
Amore (Wednesfield 2) Limited	United Kingdom
Amore Care (Holdings) Limited	United Kingdom
Amore Care Limited	United Kingdom
Amore Elderly Care (Wednesfield) Limited	United Kingdom
Amore Elderly Care Holdings Limited	United Kingdom
Amore Elderly Care Limited	United Kingdom
Amore Group (Holdings) Limited	United Kingdom
Ascent Acquisition - CYPDC, LLC	Arkansas
Ascent Acquisition - PSC, LLC	Arkansas
Ascent Acquisition, LLC	Arkansas
dba Ascent Children's Health Services	
dba Ascent	
Aspen Education Group, Inc.	California
Aspen Youth, Inc.	California
Atlanta Recovery Center, LLC	Delaware
ATS of Cecil County, LLC	Virginia
dba Cumberland Treatment Center	
dba Elkton Treatment Center	
dba Pine Heights Treatment Center	
ATS of Delaware, LLC	Virginia
dba Claymont Treatment Center	
ATS of North Carolina, LLC	Virginia
dba Carolina Treatment Center of Fayetteville	
dba Carolina Treatment Center Of Pinehurst	
dba Carolina Treatment Center Of Goldsboro	
dba Cumberland County Treatment Center	
dba Mountain Health Solutions – North Wilkesboro	
dba Mountain Health Solutions – Asheville	

SUPPLEMENTAL #1

March 28, 2016
11:49 am

Name of Subsidiary *(including dba name, if applicable)*	Jurisdiction / Country of Incorporation or Organization
Austin Behavioral Hospital, LLC	Delaware
dba Cross Creek Hospital	
Austin Eating Disorders Partners, LLC	Missouri
Autism (GB) Limited	United Kingdom
Autism TASCC Services Limited	United Kingdom
Baton Rouge Treatment Center, LLC	Louisiana
dba Baton Rouge Treatment Center	
dba North Louisiana Treatment Center	
dba North Shore Treatment Center	
Bayside Marin, Inc.	Delaware
dba Bayside Marin I	
dba Bayside Marin II	
dba Bayside Marin III	
dba Bayside Marin IV	
BCA of Detroit, LLC	Delaware
Beckley Treatment Center, LLC	West Virginia
dba Beckley Treatment Center	
Behavioral Centers of America, LLC	Delaware
Belmont Behavioral Hospital, LLC	Delaware
Belmont Physician Services, LLC	Delaware
Bethlehem Behavioral Health, LLC	Delaware
BGI of Brandywine, LLC	Virginia
dba Bowling Green at Brandywine	
Blenheim Healthcare Limited	United Kingdom
Blue Ridge Mountain Recovery Center, LLC	Delaware
Bowling Green Inn of Pensacola, LLC	Virginia
dba Twelve Oaks Treatment Center	
dba Wellness Resource Center	
Bowling Green Inn of South Dakota, Inc.	Virginia
dba Keystone Treatment Center	
Burnside Care Limited	United Kingdom
California Treatment Services, LLC	California
dba Recovery Solutions of Santa Ana	
Capestrano Investment Company, Inc.	Puerto Rico
Capestrano Realty Company, Inc.	Puerto Rico
CAPS of Virginia, LLC	Virginia
Care Continuums Limited	United Kingdom
Cartersville Center, LLC	Georgia
dba Cartersville Center	
Cascade Behavioral Holding Company, LLC	Delaware
Cascade Behavioral Hospital, LLC	Delaware
Castle Homes Care Limited	United Kingdom
Castle Homes Limited	United Kingdom
Castlecare Cymru Limited	United Kingdom
Castlecare Education Limited	United Kingdom
Castlecare Group Limited	United Kingdom
Castlecare Holdings Limited	United Kingdom
Center for Behavioral Health-HA, LLC	Pennsylvania
Center for Behavioral Health-ME, Inc.	Maine
dba Discovery House	
Center for Behavioral Health-PA, LLC	Pennsylvania
Centerpointe Community Based Services, LLC	Indiana
Charleston Treatment Center, LLC	West Virginia
dba Charleston Treatment Center	
Cheadle Royal Healthcare Limited	United Kingdom
Cheadle Royal Hospital Limited	United Kingdom

SUPPLEMENTAL #1

March 28, 2016

11:49 am

Name of Subsidiary *(including dba name, if applicable)*	Jurisdiction / Country of Incorporation or Organization
Cheadle Royal Residential Services Limited	United Kingdom
Chelfham Senior School Limited	United Kingdom
Clarksburg Treatment Center, LLC	West Virginia
dba Clarksburg Treatment Center	
CO Developments Limited	United Kingdom
Cockermouth Propco Limited	United Kingdom
Commodore Acquisition Sub, LLC	Delaware
Community Addiction Services Limited	United Kingdom
Conquest Care Homes (Norfolk) Limited	United Kingdom
Conquest Care Homes (Peterborough) Limited	United Kingdom
Conquest Care Homes (Soham) Limited	United Kingdom
Cotswold Care Services Limited	United Kingdom
Coxlease Holdings Limited	United Kingdom
Coxlease School Limited	United Kingdom
CPCA, LLC	Delaware
Craegmoor (Harbour Care) Limited	United Kingdom
Craegmoor Care (Holdings) Limited	United Kingdom
Craegmoor Facilities Company Limited	United Kingdom
Craegmoor Group (No.1) Limited	United Kingdom
Craegmoor Group (No.2) Limited	United Kingdom
Craegmoor Group (No.3) Limited	United Kingdom
Craegmoor Group (No.5) Limited	United Kingdom
Craegmoor Group (No.6) Limited	United Kingdom
Craegmoor Group Limited	United Kingdom
Craegmoor Healthcare Company Limited	United Kingdom
Craegmoor Holdings Limited	United Kingdom
Craegmoor Homes Limited	United Kingdom
Craegmoor Hospitals (Holdings) Limited	United Kingdom
Craegmoor Hospitals Limited	United Kingdom
Craegmoor Learning (Holdings) Limited	United Kingdom
Craegmoor Limited	United Kingdom
Craegmoor Supporting You Limited	United Kingdom
CRC ED Treatment, LLC	Delaware
dba Center for Hope of the Sierras	
dba Montecatini	
dba Montecatini II	
dba Carolina House	
dba Carolina House-Raleigh	
dba Montecatini Outpatient Treatment Center	
CRC Group, LLC	Delaware
CRC Health Management, Inc.	Delaware
CRC Health Oregon, Inc.	Oregon
dba Allied Health Services Portland -Alder	
dba Allied Health Services Ontario	
dba Allied Health Services Portland - Belmont	
dba Allied Health Services East	
dba Allied Health Services Portland - Burnside	
dba Allied Health Services Beaverton	
dba Allied Health Services - Medford	
dba Health Services Treasure Valley	
dba Willamette Valley Treatment Center	
dba Allied Health Services for Drug Recovery	

SUPPLEMENTAL #1

March 28, 2016

11:49 am

Name of Subsidiary *(including dba name, if applicable)*	Jurisdiction / Country of Incorporation or Organization
CRC Health Tennessee, LLC	Tennessee
dba New Life Lodge	
dba New Life Recovery Services-Cookeville	
dba Mirrorlake Recovery Center	
dba New Life Recovery Services-Jacksboro	
dba New Life Recovery Services-Jamestown	
dba New Life Recovery Services-Knoxville	
dba New Life Recovery Services-Knoxville West	
CRC Health Treatment Clinics, LLC	Delaware
dba North Florida Treatment Center	
CRC Health, LLC	Delaware
dba eGetgoing	
CRC Recovery, Inc.	Delaware
dba Midcoast Treatment Center	
dba Cedar Rapids Treatment Center	
dba Ann Arbor Treatment Center	
dba Western Michigan Treatment Center	
CRC Wisconsin RD, LLC	Wisconsin
dba Burkwood Treatment Center	
Crestwyn Health Group, LLC	Tennessee
Crossroads Regional Hospital, LLC	Delaware
dba Longleaf Hospital	
Delta Medical Services, LLC	Tennessee
Detroit Behavioral Institute, Inc.	Massachusetts
DHG Services, LLC	Delaware
Discovery House BC, LLC	Pennsylvania
Discovery House CC, LLC	Pennsylvania
Discovery House CU, LLC	Pennsylvania
Discovery House-LT, Inc.	Utah
Discovery House MA, Inc.	Maine
Discovery House Monroeville, LLC	Pennsylvania
Discovery House of Central Maine, Inc.	Maine
Discovery House Utah, Inc.	Utah
Discovery House UC, Inc.	Utah
Discovery House WC, Inc.	Maine
Discovery House, LLC	Pennsylvania
Discovery House-BR, Inc.	Maine
Discovery House-Group, LLC	Delaware
Discovery House-HZ, LLC	Pennsylvania
Discovery House-NC, LLC	Pennsylvania
Discovery House TV, Inc.	Utah
DMC-Memphis, LLC	Tennessee
Duffy's Napa Valley Rehab, LLC	Delaware
Dunhall Property Limited	United Kingdom
East Indiana Treatment Center, LLC	Indiana
dba East Indiana Treatment Center	
Eastwood Grange Company Limited	United Kingdom
Eating Disorder Treatment Associates, LLC	Kansas
Employee Management Services Limited	United Kingdom
Evansville Treatment Center, LLC	Indiana
dba Evansville Treatment Center	
Fanplate Limited	United Kingdom
Farleigh Schools Limited	United Kingdom
Farm Place Limited	United Kingdom
Ferguson Care Limited	United Kingdom
Four Circles Recovery Center, LLC	Delaware
dba Four Circles Evolution	
Fulford Grange Medical Centre Limited	United Kingdom

Name of Subsidiary *(including dba name, if applicable)*	Jurisdiction / Country of Incorporation or Organization
Galax Treatment Center, LLC	Virginia
dba Life Center of Galax	
dba New River Treatment Center	
dba Clinch Valley Treatment Center	
Generations BH, LLC	Ohio
Glentworth House Limited	England and Wales
Greenbrier Acquisition, LLC	Delaware
Greenbrier Holdings, L.L.C.	Louisiana
Greenbrier Hospital, L.L.C.	Louisiana
Greenbrier Realty, L.L.C.	Louisiana
Greenleaf Center, LLC	Delaware
dba Greenleaf Center	
Greymount Properties Limited	United Kingdom
Grovedraft Limited	United Kingdom
Habilitation Center, LLC	Arkansas
Habit Opco, Inc.	Delaware
Harbour Care (UK) Limited	United Kingdom
Health & Care Services (NW) Limited	United Kingdom
Health & Care Services (UK) Limited	United Kingdom
Heddfan Care Limited	United Kingdom
Helden Homes Limited	United Kingdom
Hermitage Behavioral, LLC	Delaware
High Quality Lifestyles Limited	United Kingdom
Highbank Private Hospital Limited	United Kingdom
HMIH Cedar Crest, LLC	Delaware
Huntington Treatment Center, LLC	West Virginia
dba Huntington Treatment Center	
Independent Community Living (Holdings) Limited	United Kingdom
Indianapolis Treatment Center, LLC	Indiana
dba Indianapolis Treatment Center	
IVRTC, LLC	Delaware
J C Care Limited	United Kingdom
Jacques Hall Developments Limited	United Kingdom
Jacques Hall Limited	United Kingdom
Johnston Care Limited	United Kingdom
Kids Behavioral Health of Montana, Inc.	Montana
dba Acadia Montana	
Lakeland Hospital Acquisition, LLC	Georgia
dba Lakeland Regional Hospital	
dba Lakeland Behavioral Health System	
Lambs Support Services Limited	United Kingdom
Lansdowne Road Limited	United Kingdom
Libra Health Limited	United Kingdom
Libra Nursing Homes Limited	United Kingdom
Life Works Community Limited	United Kingdom
Lothlorien Community Limited	United Kingdom
Manor Hall Specialists Care Partnerships Limited	England and Wales
Mark College Limited	United Kingdom
McCallum Group, LLC	Missouri
McCallum Properties, LLC	Missouri
Medical Imaging (Essex) Limited	United Kingdom
Middleton St George Healthcare Limited	United Kingdom
Millcreek School of Arkansas, LLC	Arkansas
Millcreek Schools, LLC	Mississippi

SUPPLEMENTAL #2

March 28, 2016

11:49 am

Name of Subsidiary *(including dba name, if applicable)*	Jurisdiction / Country of Incorporation or Organization
Milwaukee Health Services System, LLC	California
dba 10th Street Clinic	
dba River's Shore Clinic	
dba Madison Health Services	
dba Valley Health Services	
dba Wausau Health Services	
Mount Bachelor Educational Center, Inc.	Oregon
Name of Subsidiary	Country of Incorporation
New Directions (Bexhill) Limited	United Kingdom
New Directions (Hastings) Limited	United Kingdom
New Directions (Robertsbridge) Limited	United Kingdom
New Directions (St. Leonards on Sea) Limited	United Kingdom
New Leaf Academy, Inc.	Oregon
dba New Leaf Academy	
North Hill House Limited	United Kingdom
Northeast Behavioral Health, LLC	Delaware
Nottcor 6 Limited	United Kingdom
Oaktree Care Group Limited	England and Wales
Ohio Hospital for Psychiatry, LLC	Ohio
Options Treatment Center Acquisition Corporation	Indiana
dba Options Behavioral Health System	
dba Options Treatment Center	
dba YFCS OPT	
Park Royal Fee Owner, LLC	Delaware
Parkcare Homes (No. 2) Limited	United Kingdom
Parkcare Homes Limited	United Kingdom
Parkersburg Treatment Center, LLC	West Virginia
dba Parkersburg Treatment Center	
Partnerships in Care (Albion) Limited	England and Wales
Partnerships in Care (Beverley) Limited	England and Wales
Partnerships in Care (Bromley Road) Limited	England and Wales
Partnerships in Care (Brunswick) Limited	England and Wales
Partnerships in Care (Cardiff) Limited	England and Wales
Partnerships in Care (Cleveland 1) Limited	England and Wales
Partnerships in Care (Cleveland) Limited	England and Wales
Partnerships in Care (Cleveland) Property Holding Company Limited	England and Wales
Partnerships in Care (Irydene) Limited	England and Wales
Partnerships in Care (Nelson) Limited	England and Wales
Partnerships in Care (Oak Vale) Holding Company Limited	England and Wales
Partnerships in Care (Oak Vale) Limited	England and Wales
Partnerships in Care (Oak Vale) Property Holding Company Limited	England and Wales
Partnerships in Care (Pastoral) Limited	England and Wales
Partnerships in Care (Rhondda) Limited	England and Wales
Partnerships in Care (Schools) Limited	England and Wales
Partnerships in Care (Scotland) Limited	England and Wales
Partnerships in Care (Vancouver) Holding Company Limited	England and Wales
Partnerships in Care (Vancouver) Limited	England and Wales
Partnerships in Care (Vancouver) Property Holding Company Limited	England and Wales
Partnerships in Care 1 Limited	England and Wales
Partnerships in Care Investments 1 Limited	England and Wales
Partnerships in Care Investments 2 Limited	England and Wales
Partnerships in Care Limited	England and Wales
Partnerships in Care Management Limited	England and Wales
Partnerships in Care Management 2 Limited	England and Wales
Partnerships in Care Property 1 Limited	England and Wales
Partnerships in Care Property 2 Limited	England and Wales
Partnerships in Care Property 3 Limited	England and Wales
Partnerships in Care Property 4 Limited	England and Wales

Name of Subsidiary *(including dba name, if applicable)*	Jurisdiction / Country of Incorporation or Organization
Partnerships in Care Property 5 Limited	England and Wales
Partnerships in Care Property 6 Limited	England and Wales
Partnerships in Care Property 7 Limited	England and Wales
Partnerships in Care Property 8 Limited	England and Wales
Partnerships in Care Property 9 Limited	England and Wales
Partnerships in Care Property 10 Limited	England and Wales
Partnerships in Care Property 11 Limited	England and Wales
Partnerships in Care Property 12 Limited	England and Wales
Partnerships in Care Property 13 Limited	England and Wales
Partnerships in Care Property 14 Limited	England and Wales
Partnerships in Care Property 15 Limited	England and Wales
Partnerships in Care Property 16 Limited	England and Wales
Partnerships in Care Property 17 Limited	England and Wales
Partnerships in Care Property 18 Limited	England and Wales
Partnerships in Care Property 19 Limited	England and Wales
Partnerships in Care Property 20 Limited	England and Wales
Partnerships in Care Property 21 Limited	England and Wales
Partnerships in Care Property 22 Limited	England and Wales
Partnerships in Care Property 23 Limited	England and Wales
Partnerships in Care Property 24 Limited	England and Wales
Partnerships in Care Property 25 Limited	England and Wales
Partnerships in Care Property 26 Limited	England and Wales
Partnerships in Care Property 27 Limited	England and Wales
Partnerships in Care Property 28 Limited	England and Wales
Partnerships in Care Property 29 Limited	England and Wales
Partnerships in Care Property 30 Limited	England and Wales
Partnerships in Care Property 31 Limited	England and Wales
Partnerships in Care Property Holding Company Limited	England and Wales
Partnerships in Care UK 1 Limited	England and Wales
Partnerships in Care UK 2 Limited	England and Wales
Peninsula Autism Services and Support Limited	United Kingdom
PHC MeadowWood, LLC	Delaware
PHC of Michigan, Inc.	Massachusetts
PHC of Nevada, Inc.	Massachusetts
PHC of Utah, Inc.	Massachusetts
PHC of Virginia, LLC	Massachusetts
Piney Ridge Treatment Center, LLC dba Piney Ridge Treatment Center dba Piney Ridge Center dba Ridgeview Group Home	Delaware
Pomegranate Acquisition Sub, LLC	Delaware
Positive Living Limited	United Kingdom
Priory (Thetford 1) Limited	United Kingdom
Priory (Thetford 2) Limited	United Kingdom
Priory (Troup House) Limited	United Kingdom
Priory Behavioural Health Limited	United Kingdom
Priory Bristol (Property) Limited	Cayman Islands
Priory Care Homes Holdings Limited	United Kingdom
Priory Central Services Limited	United Kingdom
Priory Chadwick Lodge (Property) Limited	Cayman Islands
Priory Coach House (Property) Limited	Cayman Islands
Priory Condover (Property) Limited	Cayman Islands
Priory Coombe House (Property) Limited	Cayman Islands
Priory Eastwood Grange (Property) Limited	Cayman Islands
Priory Eden Grove (Property) Limited	Cayman Islands
Priory Education Services Limited	United Kingdom

Name of Subsidiary *(including dba name, if applicable)*	Jurisdiction / Country of Incorporation or Organization
Priory Farm Place (Property) Limited	Cayman Islands
Priory Farmfield Limited	United Kingdom
Priory Finance Company Limited	Cayman Islands
Priory Finance Property Holdings No. 1 Limited	United Kingdom
Priory Finance Property Holdings No. 2 Limited	United Kingdom
Priory Finance Property LLP	United Kingdom
Priory Grange (Holdings) Limited	United Kingdom
Priory Grange (Potters Bar) Limited	United Kingdom
Priory Grange (St Neots) Limited	United Kingdom
Priory Group Limited	United Kingdom
Priory Group No. 1 Limited	United Kingdom
Priory Group No. 2 Limited	United Kingdom
Priory Group No. 3 PLC	Cayman Islands
Priory Health No. 1 Limited	Cayman Islands
Priory Health No. 2 Limited	United Kingdom
Priory Healthcare Europe Limited	United Kingdom
Priory Healthcare Finance Co Limited	United Kingdom
Priory Healthcare Holdings Limited	United Kingdom
Priory Healthcare Investments Limited	United Kingdom
Priory Healthcare Investments Trustee Limited	United Kingdom
Priory Healthcare Limited	United Kingdom
Priory Healthcare Services Limited	Cayman Islands
Priory Hemel Grange (Property) Limited	Cayman Islands
Priory Holdings Company No 1 Limited	Cayman Islands
Priory Holdings Company No. 2 Limited	Cayman Islands
Priory Holdings Company No. 3 Limited	United Kingdom
Priory Hospitals Limited	Cayman Islands
Priory Hove (Property) Limited	Cayman Islands
Priory Investments Holdings Limited	Cayman Islands
Priory Jacques Hall (Property) Limited	Cayman Islands
Priory Marchwood (Property) Limited	Cayman Islands
Priory Mark College (Property) Limited	United Kingdom
Priory New Education Services Limited	United Kingdom
Priory New Investments Limited	United Kingdom
Priory New Investments No. 2 Limited	United Kingdom
Priory New Investments No. 3 Limited	Cayman Islands
Priory Nottingham (Property) Limited	United Kingdom
Priory Old Acute Services Limited	United Kingdom
Priory Old Forensic Services Limited	United Kingdom
Priory Old Grange Services Limited	United Kingdom
Priory Old Schools Services Limited	United Kingdom
Priory Pension Trustee Limited	United Kingdom
Priory Rehabilitation Services Holdings Limited	United Kingdom
Priory Rehabilitation Services Limited	Cayman Islands
Priory Roehampton (Property) Limited	United Kingdom
Priory Secure Services Limited	United Kingdom
Priory Securitisation Holdings Limited	United Kingdom
Priory Securitisation Limited	Isle of Man
Priory Services for Young People Limited	Cayman Islands
Priory Sheridan House (Property) Limited	Cayman Islands
Priory Sketchley Hall (Property) Limited	Cayman Islands
Priory Solutions (Property) Limited	United Kingdom
Priory Specialist Health Division Limited	United Kingdom
Priory Specialist Health Limited	Cayman Islands
Priory Sturt (Property) Limited	Cayman Islands
Priory Tadley Court (Property) Limited	

Name of Subsidiary *(including dba name, if applicable)*	Jurisdiction / Country of Incorporation or Organization
Priory Unsted Park (Property) Limited	Cayman Islands
Priory Widnes (Property) Limited	Cayman Islands
Progress Audit Services Limited	United Kingdom
Progress Care (Holdings) Limited	United Kingdom
Progress Care and Education Limited	United Kingdom
Psychiatric Resource Partners, LLC	Delaware
Public Health Solutions Limited	United Kingdom
Quality Addiction Management, Inc.	Wisconsin
Quantum Care (UK) Limited	United Kingdom
R.I.S.A.T., LLC	Rhode Island
R.J. Homes Limited	United Kingdom
Rebound Behavioral Health, LLC	South Carolina
Red River Holding Company, LLC	Delaware
Red River Hospital, LLC	Delaware
Rehabilitation Centers, LLC	Mississippi
dba Millcreek of Magee	
dba Millcreek of Pontotoc	
Renova LLP	United Kingdom
Resolute Acquisition Corporation	Indiana
dba Resolute Treatment Center	
dba Resolute Treatment Facility	
dba YFCS REL	
dba Resolute	
dba Polaris Group Home	
Richmond Treatment Center, LLC	Indiana
dba Richmond Treatment Center	
Riverview Behavioral Health, LLC	Texas
dba Vista Health Texarkana	
dba Riverview Behavioral Health	
RiverWoods Behavioral Health, LLC	Delaware
dba Riverwoods Behavioral Health	
dba Blue Ridge Mountain Recovery Center	
Robinson Kay House (Bury) Limited	United Kingdom
Rolling Hills Hospital, LLC	Oklahoma
Rossendale School Limited	United Kingdom
Rothcare Estates Limited	United Kingdom
RTC Resource Acquisition Corporation	Indiana
dba YFCS RES	
dba Resource Treatment Facility	
dba RTC Resource	
S P Cockermouth Limited	United Kingdom
Sahara Health Systems, L.L.C.	Louisiana
San Diego Health Alliance	California
dba Capalina Clinic	
dba El Cajon Treatment Center	
dba Fashion Valley Clinic	
San Diego Treatment Services, LLC	California
dba Home Avenue Clinic	
dba Third Avenue Clinic	
San Juan Capestrano Hospital, Inc.	Puerto Rico
Sapphire Care Services Limited	United Kingdom
Seven Hills Hospital, Inc.	Delaware
Shaker Clinic, LLC	Ohio
Sheltered Living Incorporated	Texas
dba Life Healing Center of Santa Fe	

Name of Subsidiary *(including dba name, if applicable)*	Jurisdiction / Country of Incorporation or Organization
Sierra Tucson Inc.	Delaware
dba Sierra Tucson	
SJBH, LLC	Delaware
Skyway House, LLC	Delaware
Sober Living by the Sea, Inc.	California
dba Sunrise Recovery Ranch	
dba The Rose of Newport Beach	
dba The Victorian of Newport Beach	
dba Sober Living IOP	
dba The Landing at Newport Beach	
Solutions (Llangarron) Limited	United Kingdom
Solutions (Ross) Limited	United Kingdom
Sonora Behavioral Health Hospital, LLC	Delaware
Southern Indiana Treatment Center, LLC	Indiana
dba Southern Indiana Treatment Center	
Southwestern Children's Health Services, Inc.	Arizona
dba Parc Place	
dba Parc Place Behavioral	
dba Oasis Behavioral Health Hospital	
Southwood Psychiatric Hospital, LLC	Pennsylvania
dba Southwood Psychiatric Hospital	
Specialised Courses Offering Purposeful Education Limited	United Kingdom
Speciality Care (Addison Court) Limited	United Kingdom
Speciality Care (Care Homes) Limited	United Kingdom
Speciality Care (EMI) Limited	United Kingdom
Speciality Care (Learning Disabilities) Limited	United Kingdom
Speciality Care (Medicare) Limited	United Kingdom
Speciality Care (Rehab) Limited	United Kingdom
Speciality Care (Rest Care) Limited	United Kingdom
Speciality Care (Rest Homes) Limited	United Kingdom
Speciality Care (UK Lease Homes) Limited	United Kingdom
Speciality Care Limited	United Kingdom
Speciality Healthcare Limited	United Kingdom
Stoke 3 Limited	United Kingdom
Stoke Trustee LLP	United Kingdom
Stoke Trustee (No 2) LLP	United Kingdom
Strathmore Care Services Limited	United Kingdom
Strathmore College Limited	United Kingdom
Structure House, LLC	Delaware
dba Wellspring at Structure House	
Sturt House Clinic Limited	United Kingdom
Success Acquisition, LLC	Indiana
SUWS of the Carolinas, Inc.	Delaware
dba SUWS Seasons	
Swift River Academy, L.L.C.	Delaware
Ten Broeck Tampa, LLC	Florida
Ten Lakes Center, LLC	Ohio
Texarkana Behavioral Associates, L.C.	Texas
dba Riverview Behavioral Health Outpatient Program	
dba Vantage Point Behavioral Health	
dba Vantage Point of Northwest Arkansas	
dba Vantage Point of the Ozarks	
dba Valley Behavioral Health System	
dba Valley Behavioral Health Outpatient Program	
dba Valley Behavioral Health System Outpatient Program	
dba Vista Health	

Name of Subsidiary *(including dba name, if applicable)*	Jurisdiction / Country of Incorporation or Organization
The Camp Recovery Center, LLC	California
dba Azure Acres	
dba Starlite Recovery Center	
dba The Camp Recovery Center	
dba Camp IOP-Campbell	
dba Camp IOP-Scotts Valley	
dba Camp IOP-Monterey	
dba Azure Acres IOP	
The Manor Clinic Limited	England and Wales
The Pavilion at HealthPark, LLC	Florida
dba Park Royal Hospital	
dba Park Royal Psychiatric Hospital at Healthpark	
dba Park Royal Outpatient Clinic	
The Refuge - Transitions, LLC	Florida
The Refuge, A Healing Place, LLC	Florida
Thetford Trustee LLP	United Kingdom
Ticehurst House Private Clinic Limited	United Kingdom
TK Behavioral Holding Company, LLC	Delaware
TK Behavioral, LLC	Delaware
Transcultural Health Development, Inc.	California
dba Coastal Recovery Center	
Treatment Associates, Inc.	California
dba Sacramento Treatment Center	
Treehome Limited	United Kingdom
Valley Behavioral Health System, LLC	Delaware
dba Valley Behavioral Health	
dba Valley Behavioral Health System	
Velocity Healthcare Limited	United Kingdom
Vermilion Hospital, LLC	Delaware
dba Vermilion Behavioral Health Systems	
dba Acadia Vermilion Hospital	
dba Optima Specialty Hospital	
Village Behavioral Health, LLC	Delaware
dba The Village	
Virginia Treatment Center, LLC	Virginia
dba Roanoke Treatment Center	
dba Lynchburg Treatment Center	
Vista Behavioral Holding Company, LLC	Delaware
Vista Behavioral Hospital, LLC	Delaware
Vita Nova, LLC	Rhode Island
Volunteer Treatment Center, LLC	Tennessee
dba Volunteer Treatment Center	
WCHS, Inc.	California
dba Colton Clinical Services	
dba Desert Treatment Clinic	
dba Canyon Park Treatment Solutions	
dba Recovery Treatment Center	
dba Riverside Treatment Center	
dba The Renton Clinic	
dba Tacoma Treatment Solutions	
dba Temecula Valley Treatment Center	
dba Vancouver Treatment Solutions	
dba Spokane Treatment Solutions	
dba Anchorage Treatment Solutions	
Webster Wellness Professionals, LLC	Missouri
Wednesfield Trustee LLP	United Kingdom
Wednesfield Trustee (No 2) LLP	United Kingdom

SUPPLEMENTAL #2

March 28, 2016

11:49 am

Name of Subsidiary *(including dba name, if applicable)*	Jurisdiction / Country of Incorporation or Organization
Wednesfield 3 Limited	United Kingdom
Wellplace, Inc.	Massachusetts
Wheeling Treatment Center, LLC	West Virginia
dba Wheeling Treatment Center	
White Deer Realty, LLC	Pennsylvania
White Deer Run, LLC	Pennsylvania
dba Cove PREP	
dba White Deer Run of Lancaster	
dba New Perspectives at White Deer Run	
dba White Deer Run at Blue Mountain	
dba New Directions at Cove Forge	
dba Cove Forge Renewal Center	
dba White Deer Run of Allentown	
dba White Deer Run of Allenwood	
dba White Deer Run of Harrisburg	
dba White Deer Run of Lewisburg	
dba White Deer Run of Lancaster	
dba White Deer Run of New Castle	
dba White Deer Run of Williamsport	
dba White Deer Run of York	
dba Cove Forge Behavioral System at Erie	
dba Cove Forge Behavioral System at Pittsburg	
dba Cove Forge Behavioral System at Williamsburg	
dba Lehigh County Center for Recovery	
Whitewell UK Holding Company 1 Limited	England and Wales
Whitewell UK Investments 1 Limited	England and Wales
Wichita Treatment Center Inc.	Kansas
Wilderness Therapy Programs, Inc.	Oregon
dba SageWalk, the Wilderness School	
Williamson Treatment Center, LLC	West Virginia
Wilmington Treatment Center, LLC	Virginia
Yorkshire Parkcare Company Limited	United Kingdom
Youth And Family Centered Services of New Mexico, Inc.	New Mexico
dba Desert Hills	
Youth Care of Utah, Inc.	Delaware
dba Pine Ridge Academy	
dba Youth Care	
ZR Builders (Derby) Limited	United Kingdom

SUPPLEMENTAL #2

March 28, 2016
11:49 am

Exhibit 23

Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in the following Registration Statements:

(1) Form S-3 (No. 333-196611) pertaining to the Acadia Healthcare Company, Inc. registration of shares of common stock;

(2) Form S-8 (No. 333-177990) pertaining to the Acadia Healthcare Company, Inc. Incentive Compensation Plan;

(3) Form S-8 (No. 333-190232) pertaining to the Acadia Healthcare Company, Inc. Incentive Compensation Plan; and

(4) Post-Effective Amendment No. 1 to Form S-4 on Form S-8 (No. 333-175523) pertaining to the PHC, Inc. 2004 Non-Employee Director Stock Option Plan, the PHC, Inc. 2003 Stock Purchase and Option Plan, the PHC, Inc. 1995 Employee Stock Purchase Plan and the PHC, Inc. 1993 Stock Purchase and Option Plan

of our reports dated February 25, 2016, with respect to the consolidated financial statements of Acadia Healthcare Company, Inc. and the effectiveness of internal control over financial reporting of Acadia Healthcare Company, Inc., included in this Annual Report (Form 10-K) of Acadia Healthcare Company, Inc. for the year ended December 31, 2015.

/s/ Ernst & Young, LLP

Nashville, Tennessee
February 25, 2016

SUPPLEMENTAL #1

March 28, 2016
11:49 am

EXHIBIT 31.1

CERTIFICATION

I, Joey A. Jacobs, certify that:

1. I have reviewed this annual report on Form 10-K of Acadia Healthcare Company, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

    a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

    b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with U.S. generally accepted accounting principles;

    c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

    d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

    a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

    b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 25, 2016

/s/ Joey A. Jacobs
Joey A. Jacobs
Chairman of the Board and Chief Executive Officer

SUPPLEMENTAL #2

March 28, 2016
11:49 am

EXHIBIT 31.2

CERTIFICATION

I, David M. Duckworth, certify that:

1. I have reviewed this annual report on Form 10-K of Acadia Healthcare Company, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with U.S. generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 25, 2016

/s/ David M. Duckworth
David M. Duckworth
Chief Financial Officer.

SUPPLEMENTAL #2

March 28, 2016
11:49 am

EXHIBIT 32.1

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of Acadia Healthcare Company, Inc. (the "Company") on Form 10-K for the year ended December 31, 2015, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Joey A. Jacobs, Chairman of the Board and Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that, to my knowledge:

1. The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

2. The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: February 25, 2016

/s/ Joey A. Jacobs
Joey A. Jacobs
Chairman of the Board and Chief Executive Officer

EXHIBIT 32.2

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of Acadia Healthcare Company, Inc. (the "Company") on Form 10-K for the year ended December 31, 2015, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, David M. Duckworth, Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that, to my knowledge:

1. The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

2. The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: February 25, 2016

/s/ David M. Duckworth
David M. Duckworth
Chief Financial Officer

Supplemental #2
-Original-

Erlanger Behavioral Health, LLC.

CN1603-012

SUPPLEMENTAL #2
March 31, 2016
11:59 am

SUPPLEMENTAL INFORMATION (No. 2)

Erlanger Behavioral Health, LLC

Application To Initiate Psychiatric Services At The Intersection Of North Holtzclaw Avenue And Citico Avenue, In Chattanooga, Tennessee, With Establishment Of An Eighty-Eight (88) Bed Inpatient Hospital By The Addition Of Seventy-Six (76) Psychiatric Beds And The Transfer Of Twelve (12) Geriatric-Psychiatric Beds From *Erlanger North Hospital*

Application Number CN1603-012

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

SUPPLEMENTAL #2
March 31, 2016
11:59 am

Supplemental Responses To Questions Of The Tennessee Health Services & Development Agency

1.) Section A, Applicant Profile, Item 6.

The *Letter of Agreement* between *Erlanger Health System* and *Acadia Healthcare* dated February 16, 2016, regarding the potential venture is noted. However, the document cites an 80 bed hospital rather than an 88 bed hospital as indicated in the applicant's letter of intent. Please revise.

Response

A copy of the *Letter of Agreement* between *Erlanger Health System* and *Acadia Healthcare* was provided with the first supplement to this CON application. In the *Letter of Agreement*, Section 4, Item b(2), it states that CON approval for a facility "for at least 80 psychiatric beds" … therefore, it may be seen that the parties contemplated a *minimum* number of 80 beds. The possibility of additional beds was known to be likely given the significant need for behavioral health services in the defined service area.

2.) Section B, Project Description, Item 1.

What type of outpatient, intensive outpatient, and partial hospitalization programs are associated with this project?

Response

Erlanger Behavioral Health will offer three levels of outpatient care to include outpatient programs and consultation, intensive outpatient programs and partial hospitalization programs.

Outpatient programs to be provided will be tailored to fit the patient's needs and diagnosis, but could include couples and family therapy, child or adolescent therapy, cognitive therapy, etc. The therapy program would follow an assessment of the individuals functioning including physical, psychological, social, educational, etc. and related challenges. Services would also include behavioral medicine provided to patients impacted by comorbid medical

conditions, such as cardiac, obstetrics, cancer, bariatrics, etc.

The intensive outpatient programs (IOP) to be provided will also be customized to individual patients but will typically be provided in group with 10 or less patients, though each patient would also be assigned and individual therapist. Common programing would include sessions on relapse prevention, urges and cravings, chemistry of addiction, stages of change and family education, as applicable. The IOP will be for persons struggling with problems associated with addictions, substance abuse, abuse and comorbidities associates with substance use, depression, schizophrenia, bipolar disorders, etc.

The partial hospitalization program will also be tailored to the individual patient but will be provided in groups to allow patients to interact with others experiencing similar problems. The program will be structured to serve as an alternative to inpatient care. The program will be more intense than care provided in the outpatient or intensive outpatient programs. Patient served will be those that are experiencing acute psychiatric symptoms that are difficult to manage but that do not require 24-hour care. Patients in the partial hospitalization program will attend structured programming throughout the day, three to five days a week and return home in the evenings. Patients will interact with psychiatrists, social workers, nurses, and other mental health practitioners.

The goal of the partial program will be to help the patient manage their lives and symptoms. Persons served in the partial hospitalization program will be those who do not pose an immediate risk to themselves or others. Services are provided for the purpose of active treatment of a person's condition to prevent relapse, hospitalization, or incarceration. The program functions as an alternative to inpatient care, as transitional care following an inpatient stay in lieu of continued hospitalization, as a step-down service, or when the severity of symptoms is such that success in a less acute outpatient setting is not likely to be effective.

3.) Section C, Need, Item 1.a (Project Specific Criteria-Psychiatric Inpatient Services A.Need, 1).

Please revise pages 32-41 which reflects the current Guidelines for Growth Standards for Psychiatric Inpatient Services according to the following:

- **It is noted the current Guidelines for Growth do not take into account population and inpatient mental health beds outside of the State of Tennessee in determining psychiatric bed need. Please revise.**

- **The population data source of Claritas has been used to determine the bed need in the proposed service area. However, the Claritas 2016 population for the proposed Tennessee service area is 992,666 which is 6.6% greater than the Tennessee Department of Health's 2016 population of 930,858 as noted in the table on page 47 of the original application. Please adjust and revise all population statistics in determining need according to the Tennessee Department of Health statistics.**

- **The inclusion of Moccasin Bend Mental Health Institute's licensed beds in the bed calculations on page 33 and in the tables and narrative response on page 34 is noted. However, the applicant incorrectly assigned Moccasin Bend Mental Health Institute's 150 licensed beds to Parkridge West Hospital-Jasper, Tennessee in the chart listing total psych/substance beds for the service area. Please include the revision in the replacement for page 35.**

- **The applicant submitted 36R which did not correspond and flow with the original application pages 36-37 and omitted information that was included in the original application. When pages 32-43 are revised and submitted, please pay particular attention that each page flows from one to the next.**

Response

The replacement pages for 32-41 of the CON application have been revised appropriately to present the Tennessee portion of the service area, and then the non-Tennessee

portion of the service area is presented in a separate table. The combined net bed need is discussed for the entire service area.

The population estimates for the Tennessee portion of the service area have been adjusted to reflect the estimates by the Tennessee Dept. of Health.

As requested, a correction to the table to accurately reflect *Moccasin Bend Mental Health Institute* has been made to the table of currently licensed psychiatric beds.

4.) Section C, Economic Feasibility, Item 2 (Funding) & Item 10.

It is noted Acadia will not finance a portion of the proposed project with a revolving line of credit, but with cash reserves. However, it is noted the Acadia Healthcare Company, Inc., Consolidated Balance Sheet for the period ending December 31, 2015 reflected total current assets of $294,143,000 and current liabilities of $290,203,000 which calculates to a current ratio of 1.01 to 1. A ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities. According to this ratio formula, it appears Acadia does not have adequate current liquidity or reserves to appropriately fund the proposed project. Please clarify.

It is noted the February 16, 2016 Joint Venture Letter of Intent indicates funding for construction of the proposed project is conditioned on 4 stage two obligations. If any of those obligations are not met, is Erlanger Health System prepared and able to fund the proposed project alone? If so, please provide the documentation.

Response

Acadia Healthcare has advised that they have a $ 300 million credit line available to fund the project. Interest on the credit line is retained at the *Acadia* corporate level. *Acadia* will contribute cash to the JV to fund development costs so no interest expense is chargeable to the project. Please see the letter from *Acadia* attached to this supplemental information.

Concerning whether the stage two obligations are not met by *Acadia*, *Erlanger Health System* has the patients and funds to develop and implement the project. However, *Erlanger* would seek another partner in the event *Acadia* is unable to execute as contemplated.

SUPPLEMENTAL #2
March 31, 2016
11:59 am

A F F I D A V I T

STATE OF TENNESSEE |
|
COUNTY OF HAMILTON |

NAME OF FACILITY Erlanger Behavioral Health, LLC

I, Joseph M. Winick, after first being duly sworn, State under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

SIGNATURE

SWORN to and subscribed before me this 30th of March, 2016, a Notary Public in and for the State of Tennessee, County of Hamilton.

ELIZABETH JONES
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

NOTARY PUBLIC

My commission expires August 8, 2018.
(Month / Day)

SUPPLEMENTAL #2
March 31, 2016
11:59 am

TABLE OF ATTACHMENTS

SUPPLEMENTAL #2
March 31, 2016
11:59 am

Description	Section / Item
Letter From *Acadia Healthcare* CFO	
CON Replacement Pages	

SUPPLEMENTAL #2
March 31, 2016
11:59 am

ATTACHMENTS

SUPPLEMENTAL #2
March 31, 2016
11:59 am

ACADIA
HEALTHCARE

March 30, 2016

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Frost Building, Third Floor
161 Rosa Parks Boulevard
Nashville, Tennessee 37203

RE: Financing Commitment
Erlanger Behavioral Health, LLC
Hamilton County

Dear Mrs. Hill:

Erlanger Behavioral Health, LLC, a proposed joint venture of Erlanger Health System and Acadia Healthcare, is applying for a Certificate of Need to establish a new psychiatric and substance abuse hospital Hamilton County.

This letter is to confirm that Acadia Healthcare will provide the approximately $25,112,600 in funding required to construct the hospital and implement that project. Acadia intends to finance these costs with cash on hand and borrowings from its existing $300 million revolving credit facility.

Acadia's most recent audited financial statements are provided in the application. Please let me know if you have any questions.

Sincerely,

David Duckworth
CFO

the possibility of a graduate medical education and training residency program in Psychiatry.

Further, *Erlanger Health System* also participates with numerous schools that provide advanced training in the areas of nursing and allied health.

[End Of Responses To Principles Of Tennessee State Health Plan – 2011 Update, pages 5 - 13]

PSYCHIATRIC INPATIENT SERVICES

[Standards & Criteria, Effective – 2000, p. 25-26]

A. Need

1. The population-based estimate of the total need for psychiatric inpatient services is 30 beds per 100,000 general population (using population estimates prepared by the Department of health and applying the data in Joint Annual Reports).

Response

The need for additional behavioral health services to serve the region has been evident at *Erlanger Health System* for some time, and the need for this project is clearly demonstrated by a detailed analysis of the service area. The defined service area is in need of an additional 219 inpatient psychiatric beds, based on the current bed need criteria.

Further, in the twelve (12) month period from Oct. 1, 2014 – Sep. 30, 2015, EHS had a total of 34,853 inpatient discharges, and of that there were 11,561 discharges with a mental health condition that needed to be treated. Further, of the 11,561 discharges with a mental condition, 6,468 of those patients were admitted through the Emergency Department. As such, Erlanger's emergency departments already provide mental health services to emergency patients with psychiatrists and clinical social workers.

As the 7th largest public health system in the nation, and the healthcare safety net for the region, *Erlanger Health System* is already the defacto provider of behavioral health services for those in need, serving those who are unable to access care elsewhere. Also, patients with cancer, cardiac or other complex medical conditions will benefit greatly from the provision of behavioral medicine provided on an outpatient basis. Having a "system of care" available to meet the needs of area residents is paramount.

The bed need calculation is derived from the current standard of thirty (30) beds per 100,000 population in the defined service area, less the current bed supply, to arrive at the "net need" for new beds in the service area. The 2016 total population for the Tennessee service area is 1,015,247; therefore, the Tennessee bed requirement is 305 (10.15 x 30), less the current bed supply of 395, yields a net over supply of 90 psychiatric beds, as demonstrated by the following table.

Psychiatric Beds - Current Supply -- Tennessee Service Area

		== Total Psych / Substance Beds For Service Area ==				
	Total Psych / SA Beds	Child & Youth Beds	Adult Psych Beds	Geriatric Beds	Substance Abuse Beds	Total Beds
Parkridge Valley Hospital - Chattanooga, TN	172	108	32	16	16	172
Erlanger North Hospital - Chattanooga, TN	12			12		12
Parkridge West Hospital - Jasper, TN	20		20			20
Moccasin Bend MHI - Chattanooga, TN	150		150			150
Skyridge Medical Center - Westside - Cleveland, TN	29		29			29
Southern Tenn Med Ctr - Winchester, TN	12		12			12
Total	395	108	243	28	16	395

(*) Bed data obtained from 2014 Tennessee *Joint Annual Reports.*

	Pop. 2016 Tenn.	Pop. 2020 Tenn.
Child / Adolescent (Age 0-17)	215,353	217,133
Adult (Age 18-64)	596,632	598,660
Geriatric (Age 65+)	203,262	233,652
	1,015,247	1,049,445
Total Est. Psychiatric Bed Need - 2016	305	
Total Est. Psychiatric Bed Need - 2020	315	

	Est. Requirement	Current Supply	Est. Need	Proposed Bed Mix
Child / Adolescent Beds - Est. Need - 2016	65	108	-43	18
Adult Beds - Est. Need - 2016	179	259	-80	46
Geriatric Beds - Est. Need - 2016	61	28	33	24
Total	305	395	-90	88

(**) Substance Abuse hospital beds included in Psychiatric beds.

However, this does not consider the bed need in the non-Tennessee portion of the service area. When taken into consideration, this presents an entirely different picture of the need for *Erlanger Behavioral Health*. The net bed need for the non-Tennessee service area is 167 additional psychiatric beds, as illustrated by the following table.

Psychiatric Beds - Current Supply -- Non - Tennessee Service Area

		== Total Psych / Substance Beds For Service Area ==				
	Total Psych / SA Beds	Child & Youth Beds	Adult Psych Beds	Geriatric Beds	Substance Abuse Beds	Total Beds
Hamilton Medical Center - Dalton, GA	7		7			7
Total	7	0	7	0	0	7

(*) Bed data obtained from *Certificates of Need* and other data sources.

	Pop. 2016 Non - Tenn.	Pop. 2020 Non - Tenn.
Child / Adolescent (Age 0-17)	135,139	134,478
Adult (Age 18-64)	345,781	343,305
Geriatric (Age 65+)	97,806	108,586
	578,726	586,369
Total Est. Psychiatric Bed Need - 2016	174	
Total Est. Psychiatric Bed Need - 2020	176	

	Est. Requirement	Current Supply	Est. Need	Proposed Bed Mix
Child / Adolescent Beds - Est. Need - 2016	41		41	18
Adult Beds - Est. Need - 2016	104	7	97	46
Geriatric Beds - Est. Need - 2016	29		29	24
Total	174	7	167	88

(**) Substance Abuse hospital beds included in Psychiatric beds.

There are currently a total of six (6) provider organizations delivering inpatient psychiatric and substance abuse/chemical dependency services at a total of eight (8) locations within the service area, for a total of 402 licensed inpatient beds.

The *combined* bed need calculation for the Tennessee and non-Tennessee portions of the service area, yields a net need for new inpatient psychiatric beds of 77 … total requirement of 479 (305 + 174), less the current bed supply of 402 (395 + 7).

Erlanger Behavioral Health will have a bed mix of twenty-four (24) Adult Psychiatric, twenty-four (24) Geriatric Psychiatric, eighteen (18) Child/Adolescent Psychiatric and twenty-two (22) Adult Chemical Dependency beds.

Erlanger Behavioral Health seeks to add seventy-six (76) new beds to the service area. *Erlanger North Hospital* will transfer it's current complement of twelve (12) licensed geriatric psychiatric beds to *Erlanger Behavioral Health* with approval and implementation of this CON application. This will be a total of eighty-eight (88) beds.

In a press release on January 28, 2016, U.S. Senator Lamar Alexander said that public legislative hearings on the mental health crisis in America are a "priority". As evidence, Sen. Alexander cited a 2014 national study by the *Substance Abuse & Mental Health Services Administration* which found that 1 in 5 adults had a mental health condition and 9.8 million adults had serious mental illness, such as schizophrenia, bipolar disorder or depression. Of these, nearly 60% of adults with mental illness did not receive care in 2014. Only about half of adolescents with a mental health condition received treatment. Further, in a study from 2010 - 2012, nearly 21% of adults in Tennessee reported having a mental illness.

In short, there is a critical need for additional inpatient psychiatric beds from the community need perspective, as well as *Erlanger's* institutional need perspective.

2. For adult programs, the age group of 18 years and older should be used in calculating the estimated total number of beds needed.

Response

As illustrated by the need information presented in item A-1, the bed need for adults is calculated based on the age group 18-64 years, and the geriatric need is calculated based on the age group over 65. Based on this methodology, the service area has a combined need for a total of 77 additional beds.

Erlanger Behavioral Health will have a bed mix of twenty-four (24) Adult Psychiatric, twenty-four (24) Geriatric Psychiatric, eighteen (18) Child/Adolescent Psychiatric and twenty-two (22) Adult Chemical Dependency beds.

3. **For child inpatient under age 13, and if adolescent program the age group of 13-17 should be used.**

Response

As illustrated by the need information presented in item A-1, the bed need for child/adolescents is calculated based on the age group 0-17 years.

Erlanger Behavioral Health will have a bed mix of eighteen (18) child/adolescent beds.

4. **These estimates for total need should be adjusted by the existing staffed beds operating in the area as counted by the Department of Health in the Joint Annual Report.**

Response

As illustrated by the need information presented in item A-1, the bed need has been adjusted by the existing staffed beds operating in the service area, as reported in the 2014 Tennessee Joint Annual Reports for hospitals.

B. Service Area

1. **The geographic service area should be reasonable and based on an optimal balance between population density and service proximity or the Community Service Agency.**

Response

The service area for this project is defined as Hamilton County, Tennessee, and the counties that surround Hamilton County in Tennessee, Georgia, Alabama and North

Carolina. The service area consists of a total of thirty (30) contiguous counties in the four (4) state geography. A complete list of the counties which comprise the service area is attached to this CON application.

This geography represents the primary, secondary and tertiary service areas for *Erlanger Medical Center*. As such, the service area is reasonable and provides optimal balance between population density and service proximity.

2. **The relationship of the socio-demographics of the service area, and the projected population to receive services, should be considered. The proposal's sensitivity to, and responsiveness to the special needs of the service area should be considered including accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, and those needing services involuntarily.**

Response

Erlanger Behavioral Health will serve adolescents and adults of all ages without discrimination, and also without regard to gender, ethnicity or ability to pay for services.

Erlanger Behavioral Health will serve all patients in need of psychiatric and substance abuse services regardless of ability to pay. Further, patients with TennCare/Medicaid coverage will be admitted and served, as will charity patients.

Erlanger Behavioral Health will accept involuntary admissions from the judicial system regardless of ability to pay.

C. Relationship To Existing Applicable Plans

1. **The proposal's relationship to policy as formulated in state, city, county, and/or regional plans and other documents should be a significant consideration.**

Response

The *Tennessee Guidelines For Growth*, which have already been addressed, identify several factors pertaining to this CON application. The *Guidelines* support delivery of services in the most medically appropriate setting, which goal this CON application serves. The *Guidelines* support those CON applications which provide services to the elderly, which goal this CON application serves. The *Guidelines* indicate that preference will be given to patient accessibility and availability, which goal this CON application serves.

According to the *Tennessee State Health Plan* "mental health problems are more prevalent in Tennessee than the national average", while "the prevalence of mental health problems and illnesses is often underestimated" … but "despite improvements in our understanding of mental health problems and illnesses often do not get treatment".[3] This CON application seeks to serve this significant need.

2. The proposal's relationship to underserved geographic areas as identified in state, city, county and/or regional plans and other documents should be a significant consideration.

Response

The extensive service area extends from Chattanooga across rural parts of four (4) States, and includes numerous counties which are designated by the *Health Resources & Services Administration* as *Medically Underserved Areas* ("MUA's"). The medically underserved area includes Chattanooga and Hamilton County, Tennessee. Further, every county in the defined service area is classified as a *Health Professional Shortage Area* ("HPSA") for mental health, and this also includes Chattanooga and Hamilton County, Tennessee.

3. The impact of the proposal on similar services supported by state appropriations should be assessed and considered.

Response

3 *Tennessee State Health Plan*, November, 2009, page 25.

It is noted that *Moccasin Bend Mental Health Institute* ("MBMHI") is a State funded psychiatric hospital in Chattanooga, Hamilton County, Tennessee. However, this project is not expected to have any impact on *MBMHI* due to the nature of the patients which this provider accepts. From the website, the mission of *MBMHI* is identified as:

> "The mission of *MBMHI* is to provide quality psychiatric services to individuals with a severe and persistent mental illness."

Also, *MBMHI's* service area is also much broader than the service area proposed. The *MBMHI* service area is 52 counties which serves all of East Tennessee extending North to the Kentucky and Virginia state lines.

MBMHI has a total of 150 acute psychiatric beds, which includes two (2) long term care units. Further, MBMHI identifies it's service area as fifty-two (52) counties in East Tennessee, this includes thirty-four (34) counties in Tennessee that are not in the service area for *Erlanger Behavioral Health*. Because *MBMHI* treats those who are severely mentally ill, it is not expected that this project will impact it's services.

4. **The proposal's relationship to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility serves acute and/or long-term patients, should be assessed and considered.**

Response

As stated in response to item B-2, *Erlanger Behavioral Health* will accept voluntary patients, as well as involuntary patients from the judicial system. Acute mental health patients will be served at this facility, not long-term patients on a residential basis.

5. **The degree of projected financial participation in the Medicare and TennCare programs should be considered.**

Response

As stated in response to item B-2, *Erlanger Behavioral Health* will participate in both the Medicare and TennCare programs.

D. Relationship To Existing Similar Services In The Area

1. The area's trends in occupancy and utilization of similar services should be considered.

Response

The utilization trend for psychiatric and substance abuse beds is presented below. Utilization for CY 2014 suggests that not all populations including special needs, are receiving these necessary services.

SUPPLEMENTAL #2
March 31, 2016
11:59 am

Psychiatric Beds - Utilization Trend

	Total Psych / SA Beds	Annual Pt. Days Available	% Change 2011-2014	Actual Discharges 2014	2013	2012	2011
Parkridge Valley Adult - Chattanooga, TN			100.0%	2,070	-	-	-
Parkridge Valley Child/Adolescent - Chattanooga, TN			-61.0%	1,211	3,004	3,073	3,106
Parkridge Medical Center - Chattanooga, TN			-100.0%	-	-	258	291
Erlanger North Hospital - Chattanooga, TN			367.9%	262	281	268	56
Moccasin Bend MHI - Chattanooga, TN			40.3%	2,999	2,768	2,340	2,138
Parkridge West Hospital - Jasper, TN			204.9%	497	465	473	163
Skyridge Medical Center - Westside - Cleveland, TN			-0.4%	840	928	959	843
Southern Tenn Med Ctr - Winchester, TN			16.4%	170	86	135	146
Total			19.4%	8,049	7,532	7,506	6,743

	Total Psych / SA Beds	Annual Pt. Days Available		Actual Patient Days 2014	2013	2012	2011
Parkridge Valley Adult - Chattanooga, TN	64	23,360	100.0%	12,420	-	-	-
Parkridge Valley Child/Adolescent - Chattanooga, TN	108	39,420	-22.6%	30,203	44,968	39,153	39,012
Parkridge Medical Center - Chattanooga, TN	11	4,015	-100.0%	-	-	2,793	3,054
Erlanger North Hospital - Chattanooga, TN	12	4,380	-1.7%	3,628	3,761	3,746	3,692
Moccasin Bend MHI - Chattanooga, TN	150	54,750	34.6%	49,875	47,908	37,970	37,055
Parkridge West Hospital - Jasper, TN	20	7,300	222.9%	4,930	5,055	5,278	1,527
Skyridge Medical Center - Westside - Cleveland, TN	29	10,585	40.6%	2,203	1,038	1,362	1,567
Southern Tenn Med Ctr - Winchester, TN	12	4,380	-6.3%	4,170	3,916	4,421	4,448
Total	406	148,190	18.9%	107,429	106,646	94,723	90,355

				Occupancy Rate 2014	2013	2012	2012
Parkridge Valley Adult - Chattanooga, TN			100.0%	53.2%	-	-	-
Parkridge Valley Child/Adolescent - Chattanooga, TN			-22.6%	76.6%	114.1%	99.3%	99.0%
Parkridge Medical Center - Chattanooga, TN			-100.0%	-	-	69.6%	76.1%
Erlanger North Hospital - Chattanooga, TN			-1.8%	82.8%	85.9%	85.5%	84.3%
Moccasin Bend MHI - Chattanooga, TN			34.6%	91.1%	87.5%	69.4%	67.7%
Parkridge West Hospital - Jasper, TN			223.0%	67.5%	69.2%	72.3%	20.9%
Skyridge Medical Center - Westside - Cleveland, TN			40.5%	20.8%	9.8%	12.9%	14.8%
Southern Tenn Med Ctr - Winchester, TN			-6.3%	95.2%	89.4%	100.9%	101.6%
Total			18.9%	72.5%	72.0%	63.9%	61.0%

NOTES
(1) Utilization data obtained from Tennessee *Joint Annual Reports*.
(2) Parkridge Valley moved it's Adult & Geriatric beds to a new campus in 2014.
(3) Utilization data not available for Hamilton Medical Center in Dalton, Georgia.

Nationally, utilization of Psychiatric services is expected to increase over the next ten (10) years between 2015 and 2025, with overall growth for inpatient service at a rate of 5% and overall growth for outpatient service at a rate of 19%. Sg2, a national healthcare consultancy firm, provides the following detail by growth factor:

Factor	Inpatient	Outpatient
Population	7%	8%
Epidemiology	1%	3%
Economy	.5%	1%
Policy	.2%	1%
Innovation & Tech.	-2%	1%

Supplemental #3
-Original-

Erlanger Behavioral Health, LLC

CN1603-012

SUPPLEMENTAL #3
April 6, 2016
11:16 am

SUPPLEMENTAL INFORMATION (No. 3)

Erlanger Behavioral Health, LLC

Application To Initiate Psychiatric Services At The Intersection Of North Holtzclaw Avenue And Citico Avenue, In Chattanooga, Tennessee, With Establishment Of An Eighty-Eight (88) Bed Inpatient Hospital By The Addition Of Seventy-Six (76) Psychiatric Beds And The Transfer Of Twelve (12) Geriatric-Psychiatric Beds From *Erlanger North Hospital*

Application Number CN1603-012

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

SUPPLEMENTAL #3

April 6, 2016
11:16 am

Supplemental Responses To Questions Of The Tennessee Health Services & Development Agency

1.) Section C, Need, Item 1a (Project Specific Criteria-Psychiatric Inpatient Services), B.2 - Service Area Demographics and Section C, Need, Item 4.A, Service Area Demographics.

It is noted in the table on page 47 of the original application the Tennessee Department of Health's 2016 service area population of 930,858. However, the applicant provided a revised Tennessee service area population in Supplemental #2 of 1,015,247 to determine need. Please complete the following table and include data for each county in your proposed service area using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau.

Variable	*County 1*	*County 2*	*County 3*	*Etc.*	*Service Area*	*Tennessee*
0-17 Population-CY (2016)						
0-17 Population-PY (2020)						
0-17 Population % Change						
0-17 Population % of Total Population						
Current Year (CY), Age 65+						
Projected Year (PY), Age 65+						
Age 65+, % Change						
Age 65+, % Total (PY)						
CY, Total Population						
PY, Total Population						
Total Pop. % Change						
TennCare Enrollees						
TennCare Enrollees as a % of Total Population						
Median Age						
Median Household Income						
Population % Below Poverty Level						

Response

As requested, the demographic table has been updated and a replacement for page no. 47 has been attached to thi supplemental information.

2.) Section C., Economic Feasibility, Item 2 (Funding) & Item 10.

Acadia Funding Scenario

A. It is noted Acadia will finance a portion of the proposed project with a $300 million available revolving line of credit and cash reserves. However, the letter from Acadia Healthcare's CFO dated March 30, 2016 does not provide the percentage of the proposed project that will be funded by cash on hand and/or from a $300 million revolving line of credit. Please provide a revised letter from Acadia Healthcare's CFO that documents the percentage from each funding source and documents the availability of cash reserves. In addition, in the letter please clarify where the cash reserves will originate since Acadia's current ratio was 1:01:1 in the Consolidated Balance Sheet for the period ending December 31, 2015.

If Acadia plans to fund the project from a $300 million revolving line of credit, please provide a letter from a financial institution that identifies the expected interest rate, term of the loan, and any anticipated restrictions or conditions.

Please complete the following table:

Acadia Funding Scenario

Funding Source	Amount	As a % of Total
Cash		
Revolving Line of Credit		
Other (please specify)		
Total Loan Amount	$25,112,600	100%

Erlanger Health System Funding Scenario

B. It is noted the applicant has a non-binding agreement with Acadia to fund the proposed $25,112,600 project. In Supplemental #2, it is noted the applicant states Erlanger Health System has the funds to develop and implement the proposed project in the event Acadia is unable to execute as contemplated. It is understood that if the agreement with Acadia cannot be executed, the applicant will seek another partner. Since the applicant only has a non-binding agreement with another entity at this time, Erlanger must document the ability to solely fund the project, if necessary. Please provide appropriate documentation (letter) of funding for the proposed project from Erlanger Health System's Chief Financial Officer. If the funds will come from a bank loan, please provide a funding letter from a financial institution that identifies the expected interest rate, term of the loan, and any anticipated restrictions or conditions. If the funds will come from existing financial resources of Erlanger Health System, please identify which account in the financial balance sheet will fund the proposed project.

Please complete the following table:

Erlanger Health System Funding Scenario

Funding Source	Amount	As a % of Total
Cash		
Borrowed Funds		
Other (please specify)		
Total Loan Amount	$25,112,600	100%

Response

As to *Acadia Healthcare* and it's ability to fully fund this project, we have attached a letter from *Acadia's* CFO dated April 4, 2016, indicating that the project will be funded through the $ 300 M revolving credit facility. The chart for *Acadia* is below.

Acadia Funding Scenario

Funding Source	Amount	As a % of Total
Cash		
Revolving Line of Credit	$ 25,112,600	100 %
Other (please specify)		
Total Loan Amount	$ 25,112,600	100 %

Additionally, we will offer the following information pertaining to *Acadia*. The current ratio referenced is as of December 31, 2015, a discrete point in time. It should be noted that "the Company had $ 135.7 million of availability under the revolving credit facility as of December 31, 2015." Please see page F-22, paragraph 5, of the audited financial statements submitted with the SEC Form 10-K. Further, on page F-22 in paragraph 4, it states that "on February 16, 2016, the Company entered into a '*Second Incremental Facility Amendment*' … borrowings under the TLA Facility were used to pay down the majority of our $ 300 million revolving credit facility."

Therefore, as of February 16, 2016, most of *Acadia's* revolving credit facility is available to fully fund the project for *Erlanger Behavioral Health*.

As to *Erlanger Health Systems'* ability to fund the project should *Acadia* not be able to, please note on the audited financial statements for *Erlanger* which were submitted with this CON application, the current ratio for *Erlanger* is 2.63 to 1, as of June 30, 2015. Therefore, *Erlanger* has the ability to fully fund this project should the need arise. A letter from *Erlanger's* CFO is attached to this supplemental information.

As requested, the chart for *Erlanger* is below.

Erlanger Health System Funding Scenario

Funding Source	Amount	As a % of Total
Cash	$ 25,112,600	100 %
Borrowed Funds		
Other (please specify)		
Total Loan Amount	$ 25,112,600	100 %

SUPPLEMENTAL #3
April 6, 2016
11:16 am

A F F I D A V I T

STATE OF TENNESSEE |
|
COUNTY OF HAMILTON |

NAME OF FACILITY Erlanger Behavioral Health, LLC

I, Joseph M. Winick, after first being duly sworn, State under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

SIGNATURE

SWORN to and subscribed before me this 5 of April (Month), 2016 (Year), a Notary Public in and for the State of Tennessee, County of Hamilton.

Shelia Hall
NOTARY PUBLIC

My commission expires June 9 (Month / Day), 2018.

SHELIA HALL
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

SUPPLEMENTAL #3
April 6, 2016
11:16 am

TABLE OF ATTACHMENTS

SUPPLEMENTAL #3

April 6, 2016
11:16 am

Description	Section / Item
Replacement Page 47	
CFO Letter - *Acadia Healthcare*	
CFO Letter - *Erlanger Health System*	

SUPPLEMENTAL #3

April 6, 2016
11:16 am

ATTACHMENTS

SUPPLEMENTAL #3
April 6, 2016
11:16 am

	Hamilton	Bradley	Marion	Grundy	Sequatchie	Bledsoe		
Current Year (2016) - Age 65+	61,073	17,879	5,763	3,021	3,195	2,628		
Projected Year (2020) - Age 65+	69,752	20,381	6,584	3,339	3,896	2,955		
Age 65+ - % Change	14.2%	14.0%	14.2%	10.5%	21.9%	12.4%		
Age 65+ - % Total	17.1%	16.9%	20.2%	22.4%	20.2%	19.8%		
Total Pop. - 2016	356,156	105,549	28,585	13,470	15,835	13,273		
Total Pop. - 2020	368,666	109,706	28,633	13,263	16,943	13,481		
Total Pop. - % Change	3.5%	3.9%	0.2%	-1.5%	7.0%	1.6%		
Median Age	40	39	43	43	42	43		
Median Household Income	$47,880	$41,575	$40,998	$26,856	$42,182	$38,450		
TennCare Enrollees	69,738	22,933	7,395	4,921	4,135	3,405		
TennCare Enrollees As % Of Total Pop.	19.6%	21.7%	25.9%	36.5%	26.1%	25.7%		
Persons Below Poverty Level	56,629	18,471	5,889	3,516	2,961	3,783		
Persons Below Poverty Level As % Of Total Pop.	15.9%	17.5%	20.6%	26.1%	18.7%	28.5%		

	Rhea	Meigs	McMinn	Polk	Franklin	Coffee		
Current Year (2016) - Age 65+	6,589	2,677	11,089	3,680	8,752	10,225		
Projected Year (2020) - Age 65+	7,571	3,151	12,650	4,134	9,972	11,573		
Age 65+ - % Change	14.9%	17.7%	14.1%	12.3%	13.9%	13.2%		
Age 65+ - % Total	19.4%	21.9%	20.4%	21.1%	20.8%	18.3%		
Total Pop. - 2016	33,934	12,221	54,449	17,442	42,097	55,932		
Total Pop. - 2020	35,216	12,462	55,724	17,812	42,681	57,865		
Total Pop. - % Change	3.8%	2.0%	2.3%	2.1%	1.4%	3.5%		
Median Age	41	44	43	43	42	40		
Median Household Income	$37,512	$33,061	$39,644	$39,434	$42,663	$39,656		
TennCare Enrollees	9,466	3,365	12,815	1,052	8,200	13,894		
TennCare Enrollees As % Of Total Pop.	27.9%	27.5%	23.5%	6.0%	19.5%	24.8%		
Persons Below Poverty Level	7,465	2,542	9,474	3,541	6,946	9,397		
Persons Below Poverty Level As % Of Total Pop.	22.0%	20.8%	17.4%	20.3%	16.5%	16.8%		

	Warren	Van Buren	Monroe	Cumberland	Loudon	Roane	Service Area	State Of Tennessee
Current Year (2016) - Age 65+	7,350	1,313	10,398	19,871	15,089	12,670	203,262	1,091,516
Projected Year (2020) - Age 65+	8,233	1,554	12,384	23,106	17,908	14,509	233,652	1,266,295
Age 65+ - % Change	12.0%	18.4%	19.1%	16.3%	18.7%	14.5%	15.0%	16.0%
Age 65+ - % Total	18.0%	23.2%	21.7%	32.1%	27.8%	22.8%	20.0%	16.0%
Total Pop. - 2016	40,872	5,651	47,980	61,910	54,261	55,630	1,015,247	6,812,005
Total Pop. - 2020	41,446	5,686	50,062	65,575	57,923	56,301	1,049,445	7,108,031
Total Pop. - % Change	1.4%	0.6%	4.3%	5.9%	6.7%	1.2%	3.4%	4.3%
Median Age	40	46	43	50	47	46	43	38
Median Household Income	$34,592	$34,250	$37,202	$38,350	$50,619	$41,726	$39,258	$44,621
TennCare Enrollees	11,584	1,410	12,154	13,158	9,459	12,068	221,152	1,331,838
TennCare Enrollees As % Of Total Pop.	28.3%	25.0%	25.3%	21.3%	17.4%	21.7%	21.8%	19.6%
Persons Below Poverty Level	7,766	1,164	9,884	10,277	7,379	10,013	177,097	1,246,597
Persons Below Poverty Level As % Of Total Pop.	19.0%	20.6%	20.6%	16.6%	13.6%	18.0%	17.4%	18.3%

B. The special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Response

As a member facility of *Erlanger Health System*, *Erlanger Behavioral Health* is a component of the safety net

SUPPLEMENTAL #3
April 6, 2016
11:16 am

ACADIA
HEALTHCARE

April 4, 2016

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Frost Building, Third Floor
161 Rosa Parks Boulevard
Nashville, Tennessee 37203

RE: Financing Commitment
Erlanger Behavioral Health, LLC
Hamilton County

Dear Mrs. Hill:

Erlanger Behavioral Health, LLC, a proposed joint venture of Erlanger Health System and Acadia Healthcare, is applying for a Certificate of Need to establish a new psychiatric and substance abuse hospital Hamilton County.

This letter is to confirm that Acadia Healthcare will provide the approximately $25,112,600 in funding required to construct the hospital and implement that project. Acadia intends to finance these costs with borrowings from its existing $300 million revolving credit facility.

Acadia's most recent audited financial statements are provided in the application. Please let me know if you have any questions.

Sincerely,

David Duckworth
CFO

erlanger

April 4, 2016

Melanie M. Hill
Executive Director
Health Services and Development Agency
Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard,
Nashville, TN 37243

RE: Certificate or Need Application –CN 1603-012
Erlanger Behavioral Health, LLC

Dear Ms. Hill:

Erlanger Health System intends to enter into a joint venture with Acadia Healthcare wherein Acadia will fund development of the above referenced project. Should Acadia not follow thru to fund the project as anticipated, Erlanger would seek another partner to implement the proposed project.

Please let me know if further information is needed.

Sincerely,

J. Britton Tabor, CPA, FACHE
Executive V.P., CFO & Treasurer

Supplemental #4
-Original-

Erlanger Behavioral Health, LLC

CN1603-012

SUPPLEMENTAL #4
April 12, 2016
9:42 am

SUPPLEMENTAL INFORMATION (No. 4)

Erlanger Behavioral Health, LLC

Application To Initiate Psychiatric Services At The Intersection Of North Holtzclaw Avenue And Citico Avenue, In Chattanooga, Tennessee, With Establishment Of An Eighty-Eight (88) Bed Inpatient Hospital By The Addition Of Seventy-Six (76) Psychiatric Beds And The Transfer Of Twelve (12) Geriatric-Psychiatric Beds From *Erlanger North Hospital*

Application Number CN1603-012

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

Supplemental Responses To Questions Of The Tennessee Health Services & Development Agency

1.) Section C, Economic Feasiility, Item 2 (Funding) & Item 10.

Acadia Funding Scenario

It is noted in Supplemental # 3 Acadia plans to fund the project from a $ 300 million revolving line of credit. As previously requested in Supplemental # 3, please provide a letter from a financial institution that identifies the amount of revolving credit available, the expected interest rate, term of the revolving line of credit, and any anticipated restrictions or conditions.

Erlanger Health System Funding Scenario

In Supplemental # 2, it is noted the applicant states Erlanger Healthsystem has the funds to develop and implement the proposed project in the event Acadia is unable to execute as contemplated. As requested by the Agency in Supplemental # 3, the applicant did not provide a funding letter from Erlanger, but instead provided a letter from Erlanger's Executive V.P, CFO and Treasurer that states Erlanger would seek another partner to implement the proposed project should Acadia not follow through to fund the project. Furthermore, the narrative response on page 5 of Supplemental # 3 reflected Erlanger would fund the $ 25,112,600 project with cash should Acadia not be able to. As previously requested in Supplemental # 3, please provide appropriate documentation (letter) of funding (cash) for the proposed project from Erlanger Health System's Chief Financial Officer in the event Acadia is unable to fund the proposed project and Erlanger is unable to find another partner. Since the funds will come from existing financial resources of Erlanger Health System, please identify which account in the financial balance sheet that will fund the proposed project.

Response

As to *Acadia Healthcare*, attached to this supplemental information is the requested letter from *Bank of America* outlining the revolving credit line which *Acadia* has previously referenced. Also, attached to this supplemental information is an updated *Agreement* between *Erlanger Health System* and *Acadia*. The new *Agreement* makes a binding commitment on the part of *Acadia* to *Erlanger* and the project.

As to *Erlanger's* portion of the response to this question, we believe that the new *Agreement* between *Erlanger* and *Acadia*, as well as the funding letter from *Bank of America* on *Acadia's* behalf addresses outstanding questions.

Additionally, we are also attaching to this supplemental information, a copy of correspondence from *Acadia* which outlines their commitment to this project and the local community, in terms of the human component as represented by current employees of *Erlanger's* Geriatric Psychiatric unit at *Erlanger North Hospital*. The correspondence demonstrates *Acadia's* commitment to all of these employees, by transferring current pay rates and length of service as well as making economic adjustments for any differences between benefit packages.

SUPPLEMENTAL #4
April 12, 2016
9:42 am

A F F I D A V I T

STATE OF TENNESSEE |
|
COUNTY OF HAMILTON |

NAME OF FACILITY Erlanger Behavioral Health, LLC

I, Joseph M. Winick, after first being duly sworn, State under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

SIGNATURE

SWORN to and subscribed before me this 11 of April (Month), 2016 (Year), a Notary Public in and for the State of Tennessee, County of Hamilton.

NOTARY PUBLIC

My commission expires June 9 (Month / Day), 2018.

SHELIA HALL
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

SUPPLEMENTAL #4
April 12, 2016
9:42 am

TABLE OF ATTACHMENTS

SUPPLEMENTAL #4
April 12, 2016
9:42 am

Description	Section / Item
Correspondence - *Erlanger & Acadia*	
Funding Letter - *Acadia Healthcare*	
Letter Of Intent - Revised	

SUPPLEMENTAL #4
April 12, 2016
9:42 am

ATTACHMENTS

SUPPLEMENTAL #4
April 12, 2016
9:42 am

Winick, Joe

From: Steve Davidson <Steve.Davidson@acadiahealthcare.com>
Sent: Thursday, April 07, 2016 4:20 PM
To: Winick, Joe; Andy Hanner
Subject: RE: Erlanger

We would hire everybody that wants to transfer. They would need to be in good standing. (licenses current, etc.) and pass a criminal background check. At Southcoast, I believe all but two came over, one nurse transferred to a medical floor, and the program director took a nursing admin job.

We did a special recognition by having the transferred employees called "founders", with a plaque in the lobby of new hospital with their names, and a thank you gift ($50 gift card). They also preferred scrubs over other employee uniforms, so that stayed consistent

Titles may change, but pay rate and length of service is transferred. Benefit package may be a little different, but we mitigate that so economics are neutral on employees.

From: Winick, Joe [mailto:Joe.Winick@erlanger.org]
Sent: Thursday, April 07, 2016 3:12 PM
To: Andy Hanner
Cc: Steve Davidson
Subject: Erlanger

Andy – I am meeting tonight with the mental health staff at Erlanger North ...where we have the 12 bed geriatric program that we plan to integrate into new facility. I'm sure the key question from staff will revolve around employment prospects, opportunities, etc. in the new hospital. I would expect that Acadia would give current employees priority consideration relative to employment with the JV, but I wanted to get your thoughts on subject. I'd like to ease any discomfort to the extent possible. Your thoughts/guidance on this matter? Thanks much.

Joe

Joseph M. Winick, FACHE
Senior Vice President
Planning, Analytics & Business Development
Erlanger Health System
Office: (423) 778-8088 | Mobile: (423) 883-1287

SUPPLEMENTAL #4

April 12, 2016

8:42 am

Bank of America
Merrill Lynch

Global Commercial Banking
Bank of America, N.A.

CONFIDENTIAL

April 8, 2016

Melanie Hill
Executive Director
Health Services and Development Agency
Frost Building, 3rd Floor, 161 Rosa L Parks Boulevard
Nashville, TN 37243

RE: CON Filing

Dear Melanie:

Please accept this letter as confirmation that Acadia Healthcare Company, Inc. (the "Customer") has been a client of Bank of America, N.A. (the "Bank") for a period of over 5 years. During this period, the Customer has satisfactorily fulfilled its obligations to the Bank.

The Bank is the administrative agent with respect to the Customer's $300 million secured revolving credit facility for the Customer (the "Credit Facility"). As of this date, the amount outstanding under the Credit Facility is currently in the $74 million figure range leaving approximately $206 million available. The Credit Facility has an interest rate of LIBOR plus 3.25%, which results in a current interest rate of approximately 3.69%. The revolving line of credit matures in February 2019. The availability of funds under the Credit Facility is subject to certain terms, conditions and covenants set forth in the Credit Facility.

This letter is being provided as a matter of courtesy at the request of the Customer. Please note that the information provided by the Bank in this letter is given as of the date of this letter and is subject to change without notice, and is provided in strict confidence to you for your own use only, without any responsibility, guarantee, representation, warranty (expressed or implied), commitment or liability on the part of the Bank, its parents, subsidiaries or affiliates or any of its or their directors, officers or employees to you or any third party, and none of them assumes any duties or obligations to you in connection herewith or any transaction between you or your affiliates and the Customer. This letter is not to be quoted or referred to without the Bank's prior written consent. The Bank cannot provide any opinions of the creditworthiness of the Customer or any of its affiliates, and the above information does not constitute an opinion of the Bank of the ability of the Customer to successfully perform its obligations under any agreement it may enter into with you, the Bank or any other person or entity.

The Bank has no duty and undertakes no responsibility to update or supplement the information set forth in this letter.

Very truly yours,

By: E. Mark Hardison
Name: Mark Hardison
Title: Senior Vice President

414 Union Street, 4th Floor
TN1-100-04-17, Nashville, TN 37219-1697

SUPPLEMENTAL #4
April 12, 2016
9:42 am

ACADIA HEALTHCARE

Direct Phone: 615-861-7339
Email: steve.davidson@acadiahealthcare.com

April 11, 2016

By Email (Joe.Winick@Erlanger.org)
Joseph M. Winick, FACHE
Senior Vice President
Planning, Analytics & Business Development
Erlanger Health System
975 E 3rd Street
Chattanooga, TN 37403

Re: Joint Venture for 88 Bed Behavioral Hospital – Letter of Intent

Dear Joe:

This letter reflects the terms of Acadia Healthcare Company, Inc.'s ("Acadia's") agreement to enter into a joint venture arrangement (the "Transaction") with Erlanger Health System ("Erlanger") to develop, build and operate a new 88-bed inpatient psychiatric facility (the "Facility") that would provide a full range of inpatient and outpatient behavioral health services, on or near the Erlanger campus.

1. **Proposed Transaction Structure.** Based upon the information available to us to date, Acadia anticipates a two stage transaction structure. During the first stage, Erlanger would form a new entity (the "Venture") to own and operate the Facility which, initially, would be wholly-owned by Erlanger. The parties rights and obligations during the first stage would be governed by a Pre-Organizational Agreement. Upon obtaining a final, non-appealable Certificate of Need to develop and operate the Facility (the "CON"), the Transaction would enter the second stage during which Acadia would become an owner of the Venture and the Facility would be developed. The parties rights and obligations during the second stage will be governed by an Operating Agreement.

2. **First Stage Responsibilities.** During the first stage, Erlanger, at its expense, will organize the Venture and will apply for and pursue obtaining the CON. Erlanger will pursue the CON to a final, non-appealable result. The parties acknowledge that Acadia's intended relationship with the Venture will need to be disclosed during the CON process. Acadia will incur the costs of architecture, engineering and design necessary for the CON application for the Facility. Additionally, Acadia will deliver a letter to the Venture which will outline its commitment to fund the construction and development of the Facility which the Venture may use in connection with the CON application. The Venture shall obtain or shall obtain the right to acquire the real

estate for the Facility. Erlanger and Acadia would share equally, if necessary, the cost of an option on the real estate for the Facility.

3. **Second Stage Responsibilities.**

a. **Ownership of the Venture.** Upon the Venture obtaining a final and non-appealable CON, Acadia will become a member of the Venture. Erlanger and Acadia would own a percentage interest in the Venture in proportion to the value of their respective contributions. The value of the contributions, and the resulting relative percentage ownership of the Venture would be based upon an independent fair market valuation.

b. **Profit and Loss.** Each member's share of profits, losses and distributions in the Venture would be proportional to that member's percentage interest in the Venture.

c. **Contributions.** For its capital contribution to the Venture, Acadia would contribute cash in an amount to be determined, to be used for the design and construction of the Facility. For its capital contribution to the Venture, Erlanger would contribute its geriatric-psych business operated at Erlanger North Hospital and the Erlanger brand name for the Facility. Additionally, Erlanger will be credited with the value that the Venture has relating to the fair market, appraised value of the CON.

d. **Definitive Agreements.** The obligations of the parties to consummate the Transaction would be set forth in "Definitive Agreements" acceptable to each party in its sole discretion. The Definitive Agreements would detail the parties' rights and responsibilities concerning capital contributions, pro rata profit distributions, duties owed to the entity and the minority members, restrictions on transfers of interests, put and call rights, other restrictive covenants, triggers for the unwinding of the Venture, and other customary terms and conditions for a transaction of this type. The initial Definitive Agreement would be the Venture's Pre-Organizational Agreement which will have the form of the Operating Agreement for the Venture (the "Operating Agreement") and a license agreement for the Erlanger brand name attached. It is contemplated that the Operating Agreement would be fully negotiated at the outset of the Transaction but would be signed upon obtaining the CON.

e. **Working Capital Financing.** The Venture would not incur any debt other than a line of credit from Acadia, commencing upon obtaining the CON, of up to $5,000,000 for (i) working capital; (ii) general corporate purposes; and (iii) startup expenses. The parties contemplate that the Venture will purchase the real estate on which the Facility will be located using this capital, or, in the alternative, that Acadia will acquire such real estate and contribute it to the

Venture. The line of credit would bear interest at the prime rate plus 2%, would be due in full in 60 months, and would be repaid in full before distributions of profit by the Venture. The Venture would not guarantee debt of Acadia or Erlanger.

4. Closing Conditions.

a. The stage one closing would be conditioned on the following:

1. execution and delivery of Definitive Agreements;
2. approval of the Transaction by Acadia's Board of Directors;
3. approval of the Transaction by Erlanger's Board of Directors;
4. regulatory, legal, and operational diligence approval by Erlanger; and
5. regulatory, legal, and operational diligence approval by Acadia.

b. The stage two obligations of the parties including the requirement for Acadia to fund construction and the requirement for Erlanger to contribute its geriatric-psych unit to the Venture shall be conditioned on the following:

1. no material adverse change in the CON, licensure category, or the prospects of the Facility;
2. approval of a CON for the Facility for at least 88 psychiatric beds;
3. zoning and similar land use approvals for the Facility's construction issuing from the appropriate governmental authorities;
4. receipt of a written opinion or opinions from independent third party appraiser(s) with expertise in healthcare transactions, that the consideration paid or contributed in exchange for member interests in the Venture is consistent with fair market value.

5. Governance. Beginning with stage two, the Venture would be subject to oversight by a "Board of Directors" appointed by the parties and voting based on the respective ownership interests represented, provided that in no event shall any party have less than two Board members. It is anticipated Acadia would have a controlling interest in the Venture and appointment rights over a majority of the Board of Directors. The following Board of Directors decisions would require approval of (a) a majority of the appointed individuals sitting on the Board of Directors and (b) at least one Board representative of each of the parties:

a. approving the Venture's strategic business plan;
b. determining the need for additional capital contributions;
c. approving the location and design of the Facility and construction budgets;
d. extraordinary capital expenditures including long term leases;
e. approving incurrence of extraordinary debt;
f. expanding or reducing the number of beds at the Facility;
g. admitting any new member;

h. creating or issuing additional membership interests and/or new classes of membership interests;
i. granting any lien or security interest (except for those in the ordinary course of business not in excess of $1,000,000) on or in any of the Venture's assets or property;
j. making loans to, or acquiring equity interests in, any other person or entity;
k. selling or otherwise disposing of assets of the Venture, other than in the ordinary course of business;
l. agreeing to any contract restricting the Venture's right to make distributions to its members, or agreeing to pay any distributions in respect of member units in any form other than cash or in any manner other than to the members in accordance with their membership percentage interests;
m. amending the Venture's articles or organization, operating agreement, or name;
n. entering into, renewing or terminating any lease, contract or agreement or any other transaction or arrangement (whether or not involving payments or remuneration) between the Venture and any member or affiliate of a member;
o. approving any transfer of the equity interests held by a member, whether by direct sale, merger, or exchange;
p. approving any merger, sale, restructuring, or recapitalization of the Venture or causing the Venture to convert to a different form of entity;
q. filing a petition requesting or consenting to an order for relief under the federal bankruptcy laws or to dissolve the Venture;
r. leasing any portion of the real property owned by the Venture other than in the ordinary course of business;
s. redeeming or repurchasing by the Venture of any member units, other than on a pro rata basis to all members;
t. hiring and retention of the CEO, CFO and CNO of the Facility;
u. entering into any corporate integrity agreement or settlement agreement in connection with any government investigation or whistleblower suit; and
v. making other extraordinary material decisions as set forth in the Definitive Agreements.

The Definitive Agreements would include a mechanism for resolving certain deadlocks that may arise in connection with a governance decision.

6. Financial Statements. The Definitive Agreements will provide for the delivery of annual Acadia-level consolidated and Venture-level audited, and monthly Venture-level unaudited financial statements of the Facility.

7. Charity Care Policy. The Operating Agreement will contain covenants ensuring that the Venture (i) is operated and managed in a manner that does not jeopardize Erlanger's tax-exempt status, and (ii) recognizes and promotes Erlanger's objective of providing charity care. Specifically, the Operating Agreement will provide that the Venture will provide healthcare services for a broad cross-section of the community, adopt high standards for the quality of

patient care, provide a reasonable level of charity care to the community served by the Venture and collaborate with Erlanger on the provision of uncompensated care.

8. **Corporate Office Services; Management.** Pursuant to a services agreement to be entered into between the Venture and Acadia, Acadia's corporate office would provide corporate office management services to the Venture, to include support in the following areas: operations management, finance and accounting, legal advice and counsel, internal audit, clinical quality and compliance, risk management, insurance, human resources, recruiting, payroll, information technology, tax, billing and collecting, marketing, managed care contracting, and business office support. Acadia would charge the Venture a management fee equal to 2% of the Venture's revenue for these corporate office services, and would pass through to the Venture without markup the following expenses: (a) the actual reasonable costs of outside consultants, legal counsel, tax counsel and outside auditors; (b) a proportional amount of Acadia's facilities' costs for software licenses, insurance and employee benefits; and (c) the direct costs of Adadia's call center, web design and marketing staff to the extent dedicated to marketing the Facility, not to exceed .05% of annual Venture revenue, the actual reimbursable third party expenses of Acadia's corporate office staff, incurred in providing services to the Venture, in accordance with Acadia's Expense Reimbursement Policy. As the anticipated majority member, Acadia would be responsible for the day-to-day operations, management and control of the Facility. Acadia would consolidate the results of the operations of the Facility with its company financial statements.

9. **Noncompetition.** The Definitive Agreements would provide that Acadia and Erlanger would covenant and agree with one another and each other's affiliates that, during the Non-Compete Period (defined below) and within the Non-Compete Area (defined below), they would not directly or indirectly, with the exception of the Facility and specified other exceptions, own, acquire, lease, manage, consult for, serve as agent or subcontractor for, finance, invest in, own any part of or exercise management control over any facility or business that primarily provides services that are the same or similar to the services provided by the Facility, provided that the non-compete will exclude care provided by Erlanger in any emergency department or any service provided in an acute care setting which is accompanied by or incidental to a general medical condition which requires the patient's presence at an Erlanger facility. The "Non-Compete Period" would, for each member respectively, commence on the date of such member's acquiring any membership interest in the Venture (each a "Membership Date") and terminate on the second anniversary of such member's liquidation or termination of all such membership interests. The "Non-Compete Area" would mean the area within a twenty-five (25) mile radius of the Facility, including any satellite locations thereof. In addition, during the Noncompete Period, the members shall not solicit for employment or employ any person (at or above a certain level) who is then employed by the Venture or a party, subject to exceptions for general solicitation activity not targeted as such persons.

10. **Access and Information.** The parties will furnish to one another and their respective representatives such CON, licensure, regulatory and such other information relating to the Transaction as another party or its representatives may from time to time reasonably request.

All such access, investigations, contacts and inspections to be conducted by the requesting party and its representatives shall be conducted in consultation with the other parties and in such a manner as not to interfere unduly with the normal conduct of the other parties' business.

11. Confidentiality; Public Announcement. The terms of this Letter of Intent are subject, in all respects, to section 3 of the parties' Memorandum of Understanding dated July ___, 2015 ("MOU"). In all other respects the MOU is hereby terminated. The timing and content of any announcements, press releases or any public statements concerning the Transaction (including the CON process) shall be determined by mutual agreement of the parties, unless, with respect to Acadia, in the judgment of Acadia upon advice of counsel, disclosure is otherwise required by Acadia by applicable law or by the applicable rules of any stock market on which Acadia's securities are listed or quoted, provided that Acadia shall use commercially reasonable efforts consistent with such applicable law to consult with Erlanger with respect to the text thereof.

12. Exclusivity. The parties contemplate the expenditure of substantial sums of time and money in connection with legal, accounting, financial, and due diligence work to be performed in conjunction with the proposed transaction prior to execution of the Definitive Agreements. For purposes of inducing one another to execute this Letter of Intent, during the period from the date of acceptance of this Letter of Intent specified below to July 31, 2016, the parties and their directors, officers, affiliates, agents and employees shall not, without the prior written consent of the other parties hereto, directly or indirectly, solicit or entertain offers from, negotiate with, or in any manner encourage, discuss, accept or consider any proposal of any other person relating to the acquisition, construction, joint venture, or management of a psychiatric or substance abuse facility similar in nature and location to the proposed Facility.

13. Termination of Letter of Intent. This Letter of Intent shall terminate upon the earliest to occur of (i) written notice of termination by Erlanger to Acadia; (ii) the execution of Definitive Agreements; or (iii) the failure of the parties to negotiate fully the Operating Agreement by December 31, 2016. Paragraphs 11 through 14 of this Letter of Intent shall survive the expiration or termination of this Letter of Intent.

14. Governing Law. This Letter of Intent shall be governed and construed in accordance with the laws of the State of Tennessee without regards to principles of conflicts of laws.

We are very pleased to submit this Letter of Intent. The Transaction is a priority for Acadia and we are prepared to commit the necessary resources to complete the Transaction expeditiously. Any questions regarding this Letter of Intent should be directed to Steve Davidson, Chief Development Officer, at 615-861-6000 or via email at steve.davidson@acadiahealthcare.com. We thank you for your consideration and look forward to working with you.

SUPPLEMENTAL #4
April 12, 2016
9:42 am

If you are in agreement with the terms of this Letter of Intent, please sign and return one copy to us and each party should retain one copy for its records.

Sincerely,

Steve Davidson
Chief Development Officer

Agreed and Accepted:

Erlanger Health System
By: Joseph M. Wilrick
Its: SVP

Supplemental #5
-Original-

Erlanger Behavioral Health

CN1603-012

SUPPLEMENTAL #5
April 27, 2016
10:10 am

SUPPLEMENTAL INFORMATION (No. 5)

Erlanger Behavioral Health, LLC

Application To Initiate Psychiatric Services At The
Intersection Of North Holtzclaw Avenue And Citico Avenue,
In Chattanooga, Tennessee, With Establishment
Of An Eighty-Eight (88) Bed Inpatient Hospital
By The Addition Of Seventy-Six (76) Psychiatric Beds
And The Transfer Of Twelve (12) Geriatric-Psychiatric Beds
From *Erlanger North Hospital*

Application Number CN1603-012

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

SUPPLEMENTAL #5
April 27, 2016
10:10 am

Supplemental Responses To Questions Of The Tennessee Health Services & Development Agency

1.) **Section B, Project Description, Item 1.**

Please provide a replacement page 12 to reflect the revised ownership structure as reflected in the document *Unanimous Written Consent Action Of The Directors Of Erlanger Behavioral Health, LLC*.

Response

As requested, replacement pages 12 and 13 are attached to this supplemental information.

2.) **Section C, Economic Feasibility, Item 2 (Funding).**

Please provide a replacement page 53 to reflect the revised funding of the proposed project.

Response

As requested, replacement page 53 is attached to this supplemental information.

3.) **Section C, Economic Feasibility, Item 4 (Projected Data Chart).**

It is noted in the document *Unanimous Written Consent Action Of The Directors Of Erlanger Behavioral Health, LLC*, Acadia Healthcare Company, Inc, commits to provide a line of credit up to $ 5,000,000 to finance working capital, general corporate expenses, and start up expenses. Please submit a revised *Projected Data Chart* that reflects interest from the $ 5,000,000 Line of Credit as a Capital Expenditure.

Response

Acadia borrows and repays funds to its lender from its $300 million credit line for general corporate purposes, as needs dictate. Such borrowings are not project specific. As a result, no interest is charged to any one specific project.

4.) Section C, Economic Feasibility, Item 2 (Funding) & Item 10.

It is noted the funding for this proposed project has changed several times since the application was originally filed as evidenced by following original application and subsequent supplemental responses.

- March 15, 2016-Original application: Funded by Acadia, $25,112,600 with Cash on hand and revolving cash on hand.

- March 28, 2016-1st Supplemental Response: Acadia specifies its contribution will be cash. Acadia does not plan to utilize a credit facility to fund the proposed project.

- March 31, 2016-2nd Supplemental Response: Acadia Healthcare advises that they have a $300 million line of credit to fund the project. Interest on the credit line will be retained at the Acadia corporate level. Acadia will contribute cash to the Joint Venture to fund development costs so no interest expense is chargeable to the project.

- April 6, 2016-3rd Supplemental Response: A letter from Acadia's CFO indicates the project ($25,112,600) will be funded through a $300 million revolving credit facility.

- April 12, 2016-4th Supplemental Response: An April 8, 2016 letter from Bank of America states $206 million is available from Acadia $300 million secured revolving credit facility and matures in February 2019.

- April 19, 2016-Additional Information Submitted-In Unanimous Written Consent Action of the Directors of Erlanger Behavioral Health, LLC Exhibit-A Contribution Agreement (Contribution Agreement) Acadia commits to provide the cash necessary to fund the architecture, engineering, design, and construction of the new 88 bed inpatient psychiatric facility which is anticipated to be $25,000,000. The applicant

commits to provide a line of credit of up to $5,000,000 to finance working capital, general corporate expenses, and start-up expenses.

Furthermore, it is noted in the *Unanimous Written Consent Action of the Directors of Erlanger Behavioral Health, LLC Exhibit-A Contribution Agreement* that Acadia will finance $25,000,000 of the proposed project with cash reserves. However, it is noted the Acadia Healthcare Company, Inc. Consolidated Balance Sheet for the period ending December 31, 2015 reflected total current assets of $294,143,000 and current liabilities of $290,203,000 which calculates to a current ratio of 1.01 to 1. A ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities. According to this ratio formula, it appears Acadia does not have adequate current liquidity or reserves to appropriately fund the proposed project. Please identify which account in the Acadia financial balance sheet that will fund the proposed project.

In the latest supplemental response it is noted the applicant will provide a line of credit of up to $5,000,000 to finance working capital, general corporate expenses, and start-up expenses. Please explain why this line of credit is needed while Acadia will finance the $24,067,000 estimated project cost with cash.

Please clarify where the working capital, general corporate expenses, and start-up expenses previously mentioned are located in the Project Costs Chart.

In addition, please submit a revised funding letter from Acadia's CFO that reflects the language in the document titled Unanimous Written Consent Action of the Directors of Erlanger Behavioral Health, LLC Exhibit-A Contribution Agreement.

In Supplemental #2 the applicant states interest on the $300 million line of credit to fund the project will be retained at the Acadia corporate level. In addition, Acadia will contribute cash to the Joint Venture to fund development costs so no interest expense is chargeable to the project. Please explain how interest expense it not charged to the project

since it is a result of it. If needed, please revise the Projected Data Chart to reflect interest capital expenditures.

In summary, the applicant has changed the method of funding from the original application through the supplemental responses from Acadia funding the project through cash reserves, then line of credit, and then combination of cash reserves and line of credit. Please clarify how the proposed project will be funded and make any changes, if necessary, to include but not limited to the Project Costs Chart, Projected Data Chart, Funding Letter, Consent Action Agreement, and applicable replacement pages.

Response

As 49% owner of *Erlanger Behavioral Health, LLC*, the applicant, *Acadia* has committed to fund design and construction of the proposed 88 bed behavioral health facility using cash from its $300 million credit line with *Bank of America* and to provide a $5 million credit line. Documentation on the availability of funds from this credit line is attached.

The credit line is made available to fund any operating shortfalls that may arise during startup of the new hospital. However, such a credit line may not be required at all as projections for the first year of operation are very conservative. Based on the number of patients with co-existing medical and behavioral health conditions currently served by *Erlanger*, it is expected that utilization in the first year of operation will exceed projections, eliminating the need for the credit line altogether. In this regard, please see attached correspondence from Dr. Jennie Mahaffey, *Erlanger's* Chief Of Behavioral Health. This said, the credit line is available should unidentified needs arise that require supplemental funding.

Line 9 of the *Project Cost Chart* reflects the inclusion of start-up expenses.

Acadia borrows and repays funds to its lender from its $300 million credit line for general corporate purposes, as needs dictate. Such borrowings are not project specific.

As a result, no interest is charged to any one specific project.

We apologize if past communication has not been clear; however, we have attempted to respond to questions in an appropriate and factual manner. As 49% owner of *Erlanger Behavioral Health, LLC*, *Acadia Healthcare* is committed to provide $25,000,000, more or less, to fund design and construction of the new 88 bed hospital and to provide a credit line of up to $5,000,000 should same be required. We have updated the application to reflect these changes.

SUPPLEMENTAL #5
April 27, 2016
10:10 am

A F F I D A V I T

STATE OF TENNESSEE |
|
COUNTY OF HAMILTON |

NAME OF FACILITY Erlanger Behavioral Health, LLC

I, Joseph M. Winick, after first being duly sworn, State under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

SIGNATURE

SWORN to and subscribed before me this 25th of April (Month), 2016 (Year), a Notary Public in and for the State of Tennessee, County of Hamilton.

JOY P. JACKSON
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

NOTARY PUBLIC

My commission expires October 9 (Month / Day), 2016.

SUPPLEMENTAL #5
April 27, 2016
10:10 am

TABLE OF ATTACHMENTS

SUPPLEMENTAL #5
April 27, 2016
10:10 am

Description	Section / Item
Replacement Page 12	
Replacement Page 13	
Replacement Page 53	
CFO Letter - *Acadia Healthcare*	
Bank Of America Letter	
Email Demonstrating Need For Inpatient Psychiatric Beds	

SUPPLEMENTAL #5
April 27, 2016
10:10 am

ATTACHMENTS

index ranked at 4.8, the worst of every health index measure.

Erlanger Behavioral Health will serve adult (24 beds), geriatric (24 beds), and children / adolescent (18 beds) psychiatric patients, and will also provide adult chemical dependency services (22 beds). Services will include acute inpatient care, partial hospitalization and outpatient care. Further, service will also be provided with a crisis assessment and intake center for patients on an emergency basis, as needed. Behavioral medicine will also be provided to those in need who are affected by various medical conditions.

Proposed Services & Equipment

Erlanger Behavioral Health seeks approval to construct a new state of the art, acute care psychiatric hospital, as well as initiate psychiatric services.

Ownership Structure

Erlanger Behavioral Health is majority owned by *Erlanger Health System*. With 51%, and *Acadia Healthcare* has a minority ownership of 49%.

Acadia Healthcare is the largest provider of behavioral healthcare services. *Acadia* operates a network of 585 behavioral healthcare facilities with approximately 17,100 beds in 39 states, the United Kingdom and Puerto Rico. *Acadia* provides behavioral health and addiction services to its patients in a variety of settings, including inpatient psychiatric hospitals, residential treatment centers, outpatient clinics and therapeutic school-based programs.

Acadia already operates an outpatient methadone treatment clinic in Chattanooga.

Service Area

The service area for this project is defined as Hamilton County, Tennessee, and the counties that surround Hamilton County in Tennessee, Georgia, Alabama and North Carolina. The service area consists of a total of thirty (30) contiguous counties in the four (4) state geography, which is the same service area currently served by *Erlanger Medical Center*. A complete list of the counties which comprise the service area is attached to this CON application.

Need

The need for this project is clearly demonstrated by a broad based analysis of the service area. In short, the defined service area is in need of an additional 219 inpatient psychiatric beds, based on the current Psychiatric bed need criteria.

Further, in the twelve (12) month period from Oct. 1, 2014 - Sep. 30, 2015, EHS had a total of 34,853 inpatient discharges, and of that there were 11,561 discharges with a mental health condition that needed to be treated. Of the 11,561 inpatient discharges with a mental condition, 6,468 of those patients were admitted as inpatients through the Emergency Dept.

In short, there is a critical need for additional inpatient psychiatric beds from both a community need perspective, as well as an institutional need perspective.

Existing Resources

There are currently a total of five (5) provider organizations delivering inpatient psychiatric and substance abuse / chemical dependency services at a total of seven (7) locations within the defined service area, for a total of 252 licensed inpatient beds.

Project Cost

The project cost (per *HSDA* rules) is $ 25,112,600.

Funding

Funding for this project will be provided by *Acadia Healthcare*.

Financial Feasibility

The *Projected Data Chart* shows a positive financial result in year 2 for the project, year 1 includes the start-up cost and twelve (12) months of expense, but only ten (10) months of revenue. The first two (2) months of year 1 are planned for staff training and facility setup, along with other start-up activities.

Staffing

Staffing for the project in year 2 is estimated to be

2. Identify the funding sources for this project.

a. Please check the applicable item(s) below and briefly summarize how the project will be financed. (Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)

X A. Commercial Loan -- Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions.

___ B. Tax - Exempt Bonds -- Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance.

___ C. General obligation bonds -- Copy of resolution from issuing authority or minutes from the appropriate meeting.

___ D. Grants -- Notification of intent form for grant application or notice of grant award.

___ E. Cash Reserves - Appropriate documentation from Chief Financial Officer.

___ F. Other - Identify and document funding from all other sources.

Response

The project will be funded by *Acadia Healthcare*. See letter attached to this CON application.

3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services And Development Agency.

SUPPLEMENTAL #5
April 27, 2016
10:10 am

ACADIA HEALTHCARE

April 26, 2016

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Frost Building, Third Floor
161 Rosa Parks Boulevard
Nashville, Tennessee 37203

RE: Financing Commitment
Erlanger Behavioral Health, LLC
Hamilton County

Dear Mrs. Hill:

As 49% owner of Erlanger Behavioral Health, LLC, the applicant, Acadia Healthcare commits to fund the architecture, engineering and design and construction of the new 88 bed hospital with a project cost of $25,000,000 more or less, and to provide a $5,000,000 credit line for working capital, general corporate purposes and startup expenses. The line of credit will bear interest at a rate of prime plus 2% due within 60 months and must be repaid prior to any distributions.

Acadia's most recent audited financial statements are provided in the application. Please let me know if you have any questions.

Sincerely,

David Duckworth
CFO

SUPPLEMENTAL #5

April 27, 2016
10:16 am

Bank of America
Merrill Lynch

Global Commercial Banking
Bank of America, N.A.

CONFIDENTIAL

April 8, 2016

Melanie Hill
Executive Director
Health Services and Development Agency
Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard
Nashville, TN 37243

RE: CON Filing

Dear Melanie:

Please accept this letter as confirmation that Acadia Healthcare Company, Inc. (the "Customer") has been a client of Bank of America, N.A. (the "Bank") for a period of over 5 years. During this period, the Customer has satisfactorily fulfilled its obligations to the Bank.

The Bank is the administrative agent with respect to the Customer's $300 million secured revolving credit facility for the Customer (the "Credit Facility"). As of this date, the amount outstanding under the Credit Facility is currently in the $74 million figure range leaving approximately $206 million available. The Credit Facility has an interest rate of LIBOR plus 3.25%, which results in a current interest rate of approximately 3.69%. The revolving line of credit matures in February 2019. The availability of funds under the Credit Facility is subject to certain terms, conditions and covenants set forth in the Credit Facility.

This letter is being provided as a matter of courtesy at the request of the Customer. Please note that the information provided by the Bank in this letter is given as of the date of this letter and is subject to change without notice, and is provided in strict confidence to you for your own use only, without any responsibility, guarantee, representation, warranty (expressed or implied), commitment or liability on the part of the Bank, its parents, subsidiaries or affiliates or any of its or their directors, officers or employees to you or any third party, and none of them assumes any duties or obligations to you in connection herewith or any transaction between you or your affiliates and the Customer. This letter is not to be quoted or referred to without the Bank's prior written consent. The Bank cannot provide any opinions of the creditworthiness of the Customer or any of its affiliates, and the above information does not constitute an opinion of the Bank of the ability of the Customer to successfully perform its obligations under any agreement it may enter into with you, the Bank or any other person or entity.

The Bank has no duty and undertakes no responsibility to update or supplement the information set forth in this letter.

Very truly yours,

By: E. Mark Hardison
Name: Mark Hardison
Title: Senior Vice President

SUPPLEMENTAL #5
April 27, 2016
10:10 am

Winick, Joe

From: Mahaffey, Dr. Jennie
Sent: Monday, April 25, 2016 10:25 AM
To: Winick, Joe
Subject: The need is great.

Good morning, Joe.

FYI, we have a VA patient who is day #5 in our ED currently waiting on a medical bed to open up at the VA because they also have no psych beds available. We also have 2 other patients in the ED waiting for Moc Bend currently. One is # 57 and the other is #45 on the wait list.

Jennie

Jennie Mahaffey, M.D.
Chief of Behavioral Health
UT Erlanger Behavioral Health
979 East 3rd Street, Ste A-443
Office:(423)778-2965
Fax: (423)778-2966

Original

ADDITIONAL INFORMATION

Erlanger Behavioral Health, LLC

CN1603-012

erlanger

April 19, 2016

Melanie Hill, Executive Director
Tennessee Health Services & Development Agency
502 Deaderick Street
Jackson State Office Bldg., 9th Floor
Nashville, TN 37243

RE: Erlanger Behavioral Health, LLC
CON 1603-012

Dear Ms. Hill:

Enclosed are three copies of information to supplement our previous response with respect to the above referenced CON.

Please let me know if you have questions or need further information.

Sincerely,

Joseph M. Winick, FACHE
Senior VP Planning, Analytics & Business Development

UNANIMOUS WRITTEN CONSENT ACTION
OF THE DIRECTORS OF
ERLANGER BEHAVIORAL HEALTH, LLC

The following actions are taken and the following business is transacted by the unanimous written consent of the directors (the "**Directors**") of Erlanger Behavioral Health, LLC (the "**Company**"), as of April 18, 2016 pursuant to the Tennessee Limited Liability Company Act.

WHEREAS, the Directors are aware of that certain Contribution Agreement (the "**Contribution Agreement**") between Company and Acadia Healthcare Company, Inc., a Delaware corporation ("**Acadia**"), in substantially the form attached hereto as **Exhibit A**, which contemplates the Company's issuance of a forty-nine percent (49%) membership interest in the Company in return for a cash payment of One Dollar ($1) and the capital commitment to fund the design and construction of a new 88-bed inpatient psychiatric facility, as more particularly described in the Contribution Agreement (the "**Contribution**");

WHEREAS, the Directors have determined that the Contribution and related issuance of membership interest is in the best interest of the Company; and

WHEREAS, the Directors deem it advisable, desirable, and in the best interest of the Company to approve and authorize the Contribution Agreement and all other instruments and documents necessary or desirable in effecting the Contribution and the other transactions contemplated by the Contribution Agreement.

NOW THEREFORE, BE IT RESOLVED, that the Directors hereby approve and authorize the Contribution and in connection therewith, approve and authorize the execution of the Contribution Agreement on behalf of the Company, as well as any other instruments and documents necessary or desirable in effecting the Contribution;

FURTHER RESOLVED, that the Directors hereby approve and authorize the execution and delivery by any Authorized Officer (as hereinafter defined) of the Contribution Agreement with such additional changes as such Authorized Officer reasonably believes are in the best interest of the Company, and any other instruments and documents necessary or desirable in effecting the other transactions contemplated by the Contribution Agreement;

FURTHER RESOLVED, that Robert Brooks, FACHE, Jeff Woodard, Britt Tabor, FACHE, Gregg Gentry, and Joseph Winick (each an "Authorized Officer") be, and each of them hereby is, authorized and directed, from time to time and in the name and on behalf of the Company, to do and perform all acts, to make, execute, deliver, certify, or file all such agreements, certificates, instruments, deeds, leases, assignments, notices, and other documents as may be required by, or as such officer or officers deem necessary, proper, or desirable in connection with, the performance by the Company of the foregoing resolutions, to pay such fees required by or in furtherance of the foregoing resolutions, and to take all such other steps as they may deem necessary, advisable, or convenient and proper to carry out the intent of this and the foregoing resolutions, all such actions to be performed in such forms as such officer or officers shall approve and the performance or execution thereof by such officer or officers shall be conclusive evidence of the approval thereof by such officer or officers and by these Directors;

FURTHER RESOLVED, that any and all lawful actions previously taken by any Authorized Officer of the Company in connection with the transactions contemplated by the foregoing resolutions are hereby adopted, ratified, confirmed and approved in all respects as the acts and deeds of the Company.

IN WITNESS WHEREOF, the undersigned, being all of the Directors of the Company, have executed this written consent, which may be executed in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument, each of which counterpart originals may be executed by signatures transmitted by facsimile transfers, and such facsimile transfers will be considered to be original signatures, effective as of the date first above written.

DIRECTORS:

Gregg Gentry

Joseph Winick, FACHE

Robert Brooks, FACHE

Jeff Woodard

Britt Tabor, FACHE

Exhibit A

Conribution Agreement

(see attached)

CONTRIBUTION AGREEMENT

To Erlanger Behavioral Health, LLC:

1. General. This Contribution Agreement (the "**Agreement**") is presented to Erlanger Behavioral Health, LLC, a Tennessee limited liability company (the "**Company**"), by Acadia Healthcare Company, Inc., a Delaware corporation listed on the New York Stock Exchange (the "**Investor**"), for the purposes of subscribing for, and to induce the Company to issue to the Investor, a forty-nine percent (49%) membership interest in the Company (the "**Membership Interest**") in exchange for One Dollar ($1) and the Capital Commitment (as defined in Section 2).

2. Capital Commitment. Investor commits to provide cash necessary to fund the architecture, engineering, design and construction of a new 88-bed inpatient psychiatric facility (the "**Facility**") which amount is anticipated to be approximately $25,000,000, more or less. Upon the completion of the Facility, the membership interests in the Company held by Erlanger Health System and Investor shall be adjusted to reflect the relative fair market value of their capital contributions to the Company. The value of Erlanger Health System's capital contribution shall be determined by an independent fair market value appraisal.

3. Line of Credit. Investor commits to provide a line of credit of up to $5,000,000 to Company to finance: (i) working capital; (ii) general corporate purposes; and (iii) startup expenses. The line of credit will bear interest at a rate of prime plus 2%, due within 60 months and must be repaid prior to any distributions from the Company.

4. Transfer of Membership Interest. Investor agrees that it will not transfer, assign or encumber the Membership Interest without the prior written approval of the Company.

5. Investment Intent. The Membership Interest is being acquired for investment for the account of the Investor, with the intent that the Membership Interest shall be held for investment, without the present intent of participating directly or indirectly in a distribution of the Membership Interest, and without the participation of any other entity or person. The Investor understands that the representations and warranties contained herein are to be relied upon by the Company as a basis for the exemption of the issuance of the Membership Interest from the registration requirements of the Securities Act of 1933, as amended (the "**Act**"), and the exemptions from registration contained in applicable state securities laws. The issuance of the Membership Interest will not be registered under the Act or under any state securities laws, and the Membership Interest must be held by the Investor until (and the Company shall have no obligation to recognize any sale, assignment or other transfer thereof to any person unless) it is subsequently registered under the Act and under applicable state securities laws, or unless exemptions from the registration requirements of the Act and such laws are available and approved by counsel satisfactory to the Company. The Company is not obligated to register the Membership Interest under the Act or under any state securities laws. The Company is not obligated to take any action, except as may be required by law, necessary to make Rule 144 under the Act or any other method available for resales of the Membership Interest by the Investor.

6. Information and Disclosure. The Investor acknowledges that the Company has not prepared, and that it has not been requested by the Investor to prepare, a comprehensive written prospectus or disclosure statement in connection with the issuance of the Membership Interest, covering the business, operations, management, financial condition or prospects of the Company of the nature that otherwise might be required if the sale of the Membership Interest were required to be registered under

the Act. The Investor further acknowledges that the Company, prior to the date hereof, has furnished the Investor the opportunity to ask questions of and receive answers from the Company concerning the financial and business affairs of the Company and has afforded the Investor the opportunity to verify the accuracy of all information provided or made available to the Investor by the Company.

7. Assignment. This Agreement shall be binding upon and shall inure to the benefit of the parties hereto, and their respective successors and assigns.

8. Controlling Law; Amendment; Waiver; Remedies Cumulative. This Agreement shall be construed and enforced in accordance with the laws of the State of Tennessee. This Agreement may not be altered or amended except in writing signed by the Company and the Investor. The failure of any party hereto at any time to require performance of any provisions hereof shall in no manner affect the right to enforce the same. No waiver by any party hereto of any condition, or of the breach of any term, provision, warranty, representation, agreement or covenant contained in this Agreement, whether by conduct or otherwise, in any one or more instances shall be deemed or construed as a further or continuing waiver of any such condition or breach or a waiver of any other condition or of the breach of any other terms, provision, warranty, representation, agreement or covenant herein contained.

9. Counterparts. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original. This Agreement shall become effective when one or more counterparts have been signed by each of the parties to this Agreement and delivered to each of the other parties to this Agreement.

[Signatures on following page]

This Contribution Agreement is effective as of April 18 2016.

Acadia Healthcare Company, Inc:

By: Steven T. Davidson
Its: Chief Development Officer

ACCEPTED:

Erlanger Behavioral Health, LLC:

By:
Its:

Dated: April 19, 2016